			1 - For State Registrar	State of Marylan		artment rtificate			d Me		201	) 5	410	02
46.	ACT.		Hegistrar     Decedent's Name (First, Middle, Last	t)		imouto	0, 0	Outri	2	Date of Death	g. No.		3. Time of	Death
	Physici	an :	CAtherine	KHAMM	AR				_	Month	Day	Year		A M
	/Medic		4a. Facility Name (If not institution, give		1117	4h City T	own or l	ocation of E		ecember	4c. County	of Death		
£ .	Examin	er	INION MEMOR		9/	70.019	\	TIMO				NIA		
100 N		30	5. Social Security Number 6. So			If Under 1		If Under 24		Date of Birth			place (State o	or Foreian
	Funeral Director			DM 20 73	Yrs.	Months	Days	Hours		Date of Birth (Month, Day,	1932	Col	M)	) .
	and and		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						T	10d. Inside C	ity Limits
	Mary	jo	MD NA			BAL	TIM	one					1 Yes	2 🗌 No
	1he 28a	rec	10e. Street and Number			10f. Zip (				10	g. Citizen of \	What Cou	intry?	
	With With	by Funeral Director	2939 K	OLAND ALL.			21	211			11.5	, A		
	leath ms 2:	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decede			? (Specif	y Yes or No- can, etc.)			ican Indian,	
·0	r Itar	Für	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Mexican, P	uerto Ric	can, etc.)	Blac	ck, White	, etc.	
ဗ္ဗ	urs a	by	3 ₩Vidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No	Specify:			Specify	wh	iTe	
21215-0036	ised within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Itams 23a or 28a-f show with the Medical Examinat must be untified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual	Occupati	on	· · · · · · · · · · · · · · · · · · ·	1	6b. Kind of B	usiness/li	ndustry	-
2	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work DO NOT use	retired)	ing most of	Working	1				
	or th	Son	13tr	NA	AD	MINIS	TRAT	ive		5	PORTS	Sel	"UICES	
9	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, Last)				1	8. Mother's	Name (F	First, Middle, M	aiden Suman	10)		
<u>a</u>	should be nd Mental marked c	To	Louis LIND				(	Atho	CIN	e Pet	ers.			
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (				Route Number,	-		p Code)	
	Health Health tem 27 other tra		PATRICIA . A.	SPILKER	825	E.	34,	" ST.		Itc. MD	317	18		
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	1 -	Place of Dispo cemetery, crei	sition (Name matory or oth	e of ner place)	12	Date		0c. Location -			
<u>Ĕ</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, It is Mixidial Examiner man its collised at Once.		4 Donation 5 Other (Specify		tyvien	Cren	nator	tol 1	1141	०५ 🏻	BAlto.			
Baltimore,	Departi Departi Import any In		21. Signature of Funeral Service Licen	see / 12	22	2. Name and ARTILY	Address	of Facility	STELL	A Fune	RAI He	me C	- (L) H	
_	20E = 9		faul IN	Stella		527 6				12 100	2123	4		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode	of dying,	such as car	rdiac or r	espiratory arres	st,		Approximat Interval Bet	ween
1	Physician		Immediate Cause (Final disease or condition	· Sursis								7	21 day	
	/Medical		resulting in death)	Due to (or as a conseq	uence of):							1		
	Examiner		Sequentially list conditions,	b. UTI									mon	th
	D #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):									
	nd trans	Examiner	Cause (Disease or injury that initiated events	c										
760,	te be executed ysician and te burial-transit	Ä	resulting in death) Last	Due to (or as a conseq	uence of):									
876		Ilcal	•	d										
89 J	ing p e as	Mec	IF FEMALE:											
9	ath cuttend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3	Ectopic pre					23d. Da	te of delive		Year
<u>.</u>	the e	/slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eath 5	Other (spe	crfy)					,	,	
P.O. Box	Attending Physicien: The law requires that the death certifica rideath. cetor: Atter this certificate has been signed by the ettending phety the tuneral director, page 2 should be detached for use as it by the tuneral director.	by Physician/Med	Part II. Other significant conditions of	ontributing to death but not rec	ulting in the u	ndorhina an	150 01100	in Part I		23e. Did toba	ICCO USO CONT	ributo lo	the earner of e	teath?
S,	signe signe		Tarris digitildani dendinasi d	sinibating to doctinour not not	alting in the a	indenying ca	aso giveii	mir care i.					bably 4	_
20	w requir been si should i	Completed							_		2 - 110		0401)	
Sec.	e law has t	du							_	24a. Was an autopsy			opsy findings ompletion of c	
<u> </u>	r: Th									perform 1 Yes 2			2 No	
<u> </u>	deriff certiff rector	Be	25. Was case referred to medical examiner?	Hospital:						Check only one				
5	Phys this al dii	7	1 Yes 2 No	Hospital: Inpatient 2	ER/Outpatier			4   1401311		5 Residen			<i>fy</i> )	
U	After After funer	P P	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	M 20	c. Injury a Work?	u s 2∐No	200	J. Describe nov	v injury occur	90		
Si	death death stor: / the	Cat	2 Accident investigation 3 Suicide 6 Could not be		omo farm et			2 140	201	Location (Stre	ot and Numb	or or Pu	al Poute Num	hor
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	building, etc. (Specif	y)	eet, lactory,	OITICE		201	City or Town,	State)	01 01 7101	ai / lobio iva/ii	1001,
_	spita ours ours filled		29a. Certifier Certifying Ph	ysicien: To the best of my kno	wledne, deat	h occurred a	t the time	date and c	lace, and	due to the cau	ISB(s) and ma	nner as	stated	
	• Ho • Ful e Ful etely	edical	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	ition and/or in	vestigation, i	n my opin	nion, death	occurred	at the time, dat	e and place,	and due	o the cause(s	5)
	Po th	Me	29b. Signature and title of certifier	^		29c.	License r	number		29	d. Date signe	d (Month	Day, Year)	
-	0		> Xan	J.mp		A	T24	13 8011	410		Dezal.	11. 1	2 2000	<u> </u>
h	- 1		30. Name and address of person who	completed cause of death (Iten	n 23a) (Tvpe.	Print)		20-1	10	1	CLEANU	v 17	, 2003	,
1	)		Shana O. NTI	ei, MD Uni	on M	emon	2	Hospil	41	d due to the cau at the time, dal 29				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature			7.						
	Registr	ar	DEC 9 A 20	ns &	y Sa	2026								

DHMH 17 Rev 1/2001

ORIGINAL

For State	State of Maryland /	Department of Health and Certificate of Death	C.	000 4100	3
Registrar  1. Decedent's Name (First, Middle, L	ast)	Oertinicate of Death	Reg. N	a. Time of	Death
Physician 5012000	Kn211		Menth D	16 25 130	) OM
/Medical Examiner  4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of Deat	h 4	c. County of Death	
UPPER EHEGAP	EAKE HOSPITS	AL BELFIR		HARFORD	
Funeral	Sex 7. Age (In yrs. last b	Irthday) If Under 1 Year If Under 24 Hrs  Wonths Days Hours Min.	(Month, Day, Yea		_
Director Usual Residence of Decedent	86 125		SLPT.24	1937 1 JARYLAN	.()
10a. State 10b. County	10c. City, Tov	wn or Location		10d. Inside Cit	,
TANAN HANT	GRO FOY	Lift TUS		1 Tes	2 <b>X</b> INo
10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?	
Luneral Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married	12. Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - American Indian,	
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 25 No Specify:		Specify: WHITE	
27212-0036  See dwithin 25-0036  The Marrial Status  The Marrial S	Education 16a trade completed)	<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)</li> </ul>	rking 16b.	Kind of Business/Industry	
	College (1-4or 5+)	Mill William retired		The Matheday	- \
To the secondary (0-12)    Secondary (0-12)   Secon	st)	VV 1 NI	me (First, Middle, Maide		27
TO Be d Mental to the should be should be a marked o marked to the should be a	KNEU	MAG	SY HOFME	YER	
	(Type, Print) 19	b. Mailing Address (Street and Number or Ri	ural Route Number, City	or Town, State, Zip Code) 3\	020
19a. Informant's Name/Helationship  To be a company of the company	KUSIL 11	on K. Surs Hine Lou	RT FOREST	HUL CLARYLAN	0
20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	Removal from State	of Disposition (Name of ery, cramatory or other place)	Date 20c.	Location - City or Town, State	V
	ally) - Gz.	LAIR, P.A. 3	कर रेक	BOLL HAT LIEB	Trevo
21. ign ur of Fun m Se vice Lic	enser	22. Name and Address of Facility	EBITUIS	(2) A 211	020
23a, Part1, Enter the disease, or co	mplications that caused the death. Do	o not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate	θ
Physician Immediate Cause (Final disease or condition	ly one cause on each line.  Respire	two tribers		Interval Bety Onset and E	
/Medical resulting in death)	a. Due to (or as a consequence	<del>- + +</del>			
Examiner  Exquantially list appditions	Seve	re prevmonia			
Examiner    Squartially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	· ·			
# 2006 Per an and the first of	c. Due to (or as a consequence	esotuelionea			
P.O. BOX 6876  P.O. BOX 6876  B.O. B	0.				-
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dear	th 3 Ectopic pregnancy		23d. Date of delivery	,
in the past 12 months?	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month Day Y	rear
The faw requires that the decided by the attending age 2 should be detached for use a signed by the attending age 2 should be detached for use a signed by the attending age 2 should be detached for use a signed by the attending age 2 should be detached for use a signed by the attending age 2 should be detached for use a signed by the attendance of the signed by the signed by the attendance of the signed by	contributing to death but not resulting	in the underlying cause given in Part I	23e Did tobacco	use contribute to the cause of de	leath?
Records, F and a significant conditions that the specific part of the significant conditions that the specific part of the significant conditions that the specific part of the significant conditions that the significant co	contributing to death out not resulting	in the underlying cause given in Fact.	1 ☐ Yes		Inknown
II Record The law requirements been spage 2 should			24a. Was an	24b. Were autopsy findings a	available
The tay age has page 2			autopsy performed?	prior to completion of ca death?	ause of
of Vital Records,  Physician: The law requires rthis certificate has been signeral and director, page 2 should be examined.  To Be Completed by  Solve The Completed by  To Be Completed by	6	26. Place of De	1 ☐ Yes 2 ☑ N ath  Check only one	1 Yes 2 No	
examiner?	Hospital: 1 Inpatient 2 ER/C	Other	Home 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b	Time of 28c. Injury at Injury Work?	28d. Describe how in	ury occurred	
Division  27. Manuar of Death  28. Indicated to Alternating Broading Broadi	he	M 1 □ Yes 2 □ No			
A Para determine		farm, street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Numi ite)	⊅er,
29a, Certifier PC Certifying	Physician: To the best of my knowled	ge, death occurred at the time, date and place	e, and due to the cause	s) and manner as stated.	
Section 29a. Certifier 29a. Certifie	aminer: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occ	urred at the time, date a	nd place, and due to the cause(s)	)
Division of Vital Catherna Complete by Milhin 24 hours after death.  To the Hours after death.  To the Funeral Division of Vital Catherna Complete by Milhin 24 hours after death.  To the Funeral Division.  To the Funeral Division.  To the Hours after death.  To th	1	29c. License number		Date signed (Month, Day, Year)	
- Casarfle		D0063420	) 12	. 16/2005	
	no completed cause of death (Item 23a		201.	11) 01/11/	
0.0 To 1.0 To 1.	iddig, MD 500	Upper Chesapeake &	r., Telto	MD 21014.	
Registrar	32. Registrar's Signature	andle!			
DHMH 17 Rev 1/2001	position of				

ORIGINAL

		1	State of State of Registrar	Maryland / Dep <i>Ce</i>	artment of He		I Hygiene	uub i	:1004
			Decedent's Name (First, Middle, Last)			2. Dat	e of Death	/ Year	3. Time of Death
	Physicia /Medic	al	William L. Kendall, Jr.			Dece	mber 14		12:07 p м
>	Examin		4a. Facility Name (If not institution, give street and num 1905 Glen Cove Road	ber)	4b. City, Town, or L Darlingt	on	1	County of Death Harford	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F X	. Age (In yrs. last birthday 68 Yrs.		If Under 24 Hrs. 8. Dat Hours Min. May	e of Birth inth, Day, Year) 19, 19:	Cour	elace (State or Foreign htry)
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			1	0d. Inside City Limits
	f sho	ō	Md. Harford	Dar	lington				1 ☐ Yes 2 1 No
	with the Page or 28a-	i Director	10e. Street and Number 1905 Glen Cove Road		10f. Zip Code 210	)34	10g. Citi	izen of What Cour S . A .	ntry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avant, it a Madical Examinar must be notified at QRCs.	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deced Amged Ford 1 Yes 2 If Yes, Give Year or Da	es?	If Yes, specify Cuban,	panic Origin? (Specify Ye Mexican, Puerto Rican, Specify:		14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	thin 72 ho e. an "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	(Giv life.	edent's Usual Occupati e kind of work done du DO NOT use retired)	ring most of working		ind of Business/In	
21	led wi lygien her th		12 years	sta	ationary er	ngineer 8. Mother's Name (First,		. Govern	ment
and	ntal H ed otl	Be c	17. Father's Name (First, Middle, Last) William L. Kendall, Sr.		'	Leota Heuto		Julianie)	
ĬŽ	should nd Me mark imatic	၉	19a. Informant's Name/Relationship (Type, Print)	19b. <b>Ma</b> i	ling Address (Street an	nd Number or Rural Route	Number, City o	or Town, State, Zip	Code)
Ma	alth a		Felicia R. Kendall/wife	190	5 Glen Cove	e Road, Darl	ington,	MD 2103	4
Baltimore,	Pages 1 and on the nent of He nent of He nert: If item ary or other		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from S 14 ☐ Donation 5 ☐ Other (Specify)	tate Holy Rosa	amatory or other place.	ry 12/19/20		cation - City or To timore,	_
Balti	permit. Departn Imports any inju	Ì	21. Signature of Funeral Service Licensee			Funeral Home			c.,
	•		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not each line.	nter the mode of dying,	such as cardiac or respi	ratory arrest,	, 11.0. 21	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (condition resulting in death)	or as a consequence of):	caner	nesunt	reun	1	Onset and Death
	Examiner		Sequentially list conditions, b.						
	pe.	nlnei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	и аз а сопъедиелос оп.					
,	ate be executed thysician and the burial-transit	Examiner	that initiated events c.	or as a consequence of):					
8760,	te be ysicia ne bur	dicai	d						
9 XO	leath certifica attending ph I for use as th		23b. Was decedent pregnant	ome of pregnancy	□Ectopic pregnancy			23d. Date of delive	*
O. B	at the deat by the atte	Physician/Me		int at time of death 5	Other (specify)			Month	Day Year
rds, P.	quires that n signed h uld be det	by	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause giver	n in Part I. 23	3e. Did tobacco t 1 ☐ Yes 2		he cause of death?
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Completed	Parhuso				la. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Vital	ician: The certificate harector, page	BeC	25. Was case referred to medical			26. Place of Death (Chec			
of V	d is	To	examiner? 1 \( \text{Yes}  2 \) No Hospital: 1 \( \perp \) Ir	patient 2 ER/Outpati		4   Nuising Home	-		(y)
		ion:	T_Matural 3_Ferrolling	f Injury 28b. Time n, Day Year) Injury	Work'	at 28d. De ? es 2 □ No	escribe how inju	ry occurred	
Division	I or Attandil after death. Diractor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place building	of Injury · At home, farm, s g, etc. (Specify)		28f. Lo	cation (Street ar ty or Town, State	nd Number or Run e)	al Route Number,
Ω	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only 2 Medicel Examiner: On the ba	best of my knowledge, de	ath occurred at the time	a, date and place, and du	e to the cause(s	) and manner as s	stated. o the cause(s)
	thin 24 thin 24 tha F	Medical	one) and mann 29b. Signature and title of certifier	er stated.	29c. License			ite signed (Month,	
	F 3 F 8		15 0 × 5		53:	2266	Dec	comber 1	5,2005
-	12/2		30. Name and address of person who completed cause	of death (Item 23a) (Typ	e, Print)				
Y	0		31. Date filed (Month, Day, Year) 32.	C/ T W.	Mactha-1	Relair	-,26	)	
	Sta Regist		DEG 2 0 2005	egistrar's Signature	22461				

		_	State of Maryland / Department of Hea  1- State Registrer Certificate of De		al Hygiene Reg. No	11115	41005
			Decedent's Name (First, Middle, Last)		te of Death		3. Time of Death
Е	Physicia		Warren A. Kenney	Dec	cember 1	0, 2005	10:26P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc			County of Death	
	Lxamiii	C1	6105 McKay Drive Brandywin	e	I	Prince G	eorge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24 Hrs. 8. Dat Hours Min. (Mo	te of Birth	9. Birth	place (State or Foreign
	Director		213 88 5708 XX 2 F 44 Yrs. Months Days H	Ja	$ \frac{196}{n} $	ol Mar	yľand
	p .		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. fnside City Limits
	aho	5	Maryland Prince George's Brandywine				1 ☐ Yes 2 → No
	he M	Director	10e. Street and Number 10f. Zip Code		10g Cit	izen of What Cou	intry?
	with u		6105 McKay Drive 20613			ited Sta	
	eath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa	anic Origin? (Specify Ye		14. Race - Ameri	
	r Iten	틢	1 Never Married 2 Married NYTYPes 2 No 1027		etc.)	Black, White,	, etc.
ğ	urs a	by	3 ☐ Widowed MYDivorced Year or Dates: 1900	Specify:		Specify: Wh	ite
O O	tiled within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23a or 28a-f ahow ant, the Medical Examination must be notified a	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done durin	n na most of workina	16b. K	ind of Business/Ir	ndustry
2	thin the	npie	Elementary/Secondary (0-12) College (1-4or 5+)		3.5		
2	ygien ygien yer th	S	12 Aircraft Mechan	nic I. Mother's Name <i>(First</i> .		ilitary_	
_	m = 0 =	Be	Tr. Fability (Fried Prince)	Judith Ba		Sumame)	
3	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene is and Mantal Hygiene is marked other than "natural" or Itema 23a or 28a-1 ahow aumatic avant, in a Medical Examinar must be notified at	2	Paul Anthony Kenney  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and			s Tour State 7	n Code)
a N	12 st h and 7 ia n traun		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address ( <i>Street and</i> Paul & Judith Kenney (parents) 6105 McKay Dri				p Code)
e,	Healt om 2		20a. Method of Disposition  W ABurial 2 Coremation 3 Deemoval from State  20b. Place of Disposition (Name of cemetery, crematory or other place)			ocation - City or T	own, State
ğ	nt of nt of nt of nt of		D		005   C1i	nton, Ma	rvland
Baltimore, Maryland 21215-0036	artme ortani injury		4 □Donation 5 □Other (Specify) RESULTECTION Cellie C  21. Signature of Funeral Service Ligensee 22. Name and Address o	1.			
Ba	permit. Pages 1 end 2 should by Deperment of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>pnce</u> .		Alexandria I				
			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s				Approximate fnterval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	FORME			Onset and Death
2	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. GLIBBUASTONA MULTI-  Due to (or as a consequence of):	11-DEINE	-		ZHTWON E
Н	Examiner						
16		ner	f any, leading to immediate cause. Enter Underlying				
	cuted	Examin	Cause (Disease or injury that initiated events c.				
Ö,	e exe	Ë	resulting in death) Last Due to (or as a consequence of):				
8760	Attending Physician: The law requires that the death certificate be executed rideath.  rideath.  sctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	dicai	d			_	
9 ×	ertific Jing p		IF FEMALE: 23c. If yes, outcome of pregnancy			ORA Data of dall	
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?    Dive birth   2   Fetal death   3   Ectopic pregnancy			23d. Date of deliving Month	/ery Day Year
<u>о</u> .	the de	Physician/Me	1 Yes 2 No 9 Unknown				
œ.	vrequires that the death certific been signed by the attending F should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I. 23	3e. Did tobacco	use contribute to	the cause of death?
g	uires sign ld be	d by			1 ☐ Yes 2	No 3□ Pro	bably 4 Unknown
Ö	w requir been si should	Completed		24	4a. Was an	24b. Were aut	opsy findings available ompletion of cause of
æ	he la e has age 2	Ë		10	autopsy performed? □ Yes 2 No	prior to co death? 1 ☐ Yes	
tai	an: T tificet tor, p	0	25. Was case referred to medical	6. Place of Death (Che		1 103	20110
<u>=</u>	ysick is cer direct	To B	examiner?	4 ☐ Nursing Home 5		6 ☐Other (Spec	ıfy)
0	g Ph ter th		27. Manner of Death  1 Manual 5 Pending (Month, Day Year)  28b. Time of Sec. Injury at Work?	28d. D	escribe how inju	ry occurred	
jo	andin ath. or: Aft	atio	2 Accident investigation M 1 Yes	s 2 □No			
Division of Vital Records,	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street a ity or Town, State		ral Route Number,
Ω	urs aft ral Di						
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) (Check				
	ithin (ithin or than o	Med	29b. Signature and title of certifier 29c. License no	umber	29d. Da	ate signed (Month	, Day, Year)
	6 - 2 -		1 Matte Humana) un 1023	683	H	13/05	
1	11	7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			•	
	<u>\</u>		Stewart Grossman, MD 550 North Broadway, Sui	te 1001 Bal	ltimore,	Md.	
	Sta Regist	ate	31. Date filed (Month, Day, Year)  DEC 2 0 2005				
		e:   -	BEL A U LOUS AND STATE OF				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year -lorence DECEMBER 18,2005 4:36 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON Hours Min. 8. Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days 1 □ M 200 F 213-26-2168 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City. Town or Location 10b. County 1 Yes 2 No Daltimore DUNDAIK 10g. Citizen of What Country? 10f. Zip Code USA 2/222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 Married 1 Never Married 1 ☐ Yes 2 No Specify: WKI te Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME Ker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dlanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENARD Dundalk HUSBAN L 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State View Crematory 5 Other (Specify) 12/20 21. Signature of Funeral Service tricensee

22. Nage and Address Facility

22. Nage and Address Facility

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21. Signature of Facility 4 Donation 105 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 C Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of). 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes No 24a. Was an

Physician /Medical Examiner

ettending physicien

requires that the death certificate be executed

68760.

Box

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Division of Vital Records,

Hospitel or Attending |

within 24 hours a To the Funeral D

permit. Pages 1 and 2 should be fitted will Department of Health and Mental Hygien Importent: if Item 27 is marked other the any injury or other treumatic event, Inspec.

Maryland

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

in then "natural", or Iteme 23s or 28e-1 show the Medical Examiner must be notified at

Funeral Director

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Completed

Be

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IF FEMALE:

Examine burial-transit Physician/Medical for use as the signed by the e þ cete has been sig , page 2 should b Completed ieral Director; After this certificete has I filled in by the funeral director, page 2 s Be 2

1 Inpatient

autopsy 1 Yes

3□ DOA

26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 27 No

25. Was case referred to medical examiner's 1 🗌 Yes 27. Manner of Ceath 1 Acoident

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

2 P/Outpatient 28a. Date of Injury (Month, Day Year) 8b. Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Greaker

3 Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

a

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

State

Registrar

Certification:

Medical

31. Date filed (Month, Day, Year) DEC 2 0 2005

Dalhmore ted ical 32. Registrar's Signature

**ORIGINAL** 

		,	1 - State Registrar Amend item#5 p	ate of Maryland				nd Men	tal Hygie		41007
۱	Physici		1. Decedent's Name (First, Middle, Last) GUY MARKWOOD KLIN		<del>6  63  \</del>	/		l N	Date of Death Month ECEMBE	Day Year	3. Time of Death 12:43 005
	/Medic Examin	14	4a. Facility Name (If not institution, give street GILCHRIST CENTER	and number)		4b. City, Town	n, or Location of			4c. County of Dea	ith
	Funeral Director		5. Social Security Number 6. Sex 1 1 - 0 9 - 0 1 1 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. Ia 94	st birthday) Yrs.	If Under 1 Ye Months Day	ar If Under 24	4 Hrs. 8. D	Date of Birth Month, Day, Ye LY 31	9. Bir	ont E thplace (State or Foreign ountry) ARYLAND
	Maryland f show	tor	Usual Residence of Decedent           10a. State         10b. County           MD         BALTIMORE		Town or Lo		•				10d. Inside City Limits 1 ☐ Yes 2 ∏ No
	death with the Maryland ms 23s or 28s-f show rmust be notified at	Director	10e. Street and Number 9501 PERRY BROOK	CT.		10f. Zip Cod	° 21236			. Citizen of What C	ountry?
320	be filed within 72 hours after death with the Marylan tal Hygiene d other than *natural', or Itama 23a or 28a-f show avent, the Medical Examinar must be notitied at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S med Forces? □Yes 2□XNo Yes, Give ear or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin uban, Mexican, I No Specify:	in? (Specify Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Whi	te, etc.
37.15-0036	within 72 hou iene. than *nature the Medical E	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) pltege (1-4or 5+)	(Give life. L	lent's Usual Ockind of work do. OO NOT use ref	ne during most o ired)	of working C • E •		b. Kind of Business	•
/land 2		To Be Co	17. Father's Name (First, Middle, Last) WILLIAM GUY KLINE						st, Middle, Mai		
поге, маг	Pages 1 and 2 should tient of Health and Mer int: If Item 27 is marke iry or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Remov.	phew 20b. Pla	9501 ace of Dispo		Y BROOF	K CT.	PERR <sup>2</sup>	ity or Town, State, Y HALL, c. Location - City or BALTIMO	MD • 21236 Town, State
Daltill	permit. Pa Departmen Important: any injury once.		4 Donation 5 Other (Specify)  21. Signature of Funera News e ucensee	W		. Name and Ad	dress of Facility	HENR	Y W.		& SONS CO.
876U,	Physician and // // // // // // // // // // // // //	dical Examiner	Sequentially list conditions. Lay Jacking Lorent lines late cause. Enter Underlying Cause (Disease or injury that initiated events c.	us that caused the death, use on each line.  Should be lower to (or as a consequence to (or as a conse	ence of): ence of):	er the mode of o	tying, such as ca	ardiac or res	piralory arrest,		Approximate Interval Between Onsel and Death
O. Box 68	death certifi e attending   ed for use as	hysician/Medi	in the past 12 months?	yes, outcome of pregnan □Live birth 2 □ Fetal o □ Pregnant at time of dea	death 3□	Ectopic pregna				23d. Date of de Month	olivery Day Year
rds, P	w requires that the de- been signed by the a should be detached f	by P	Part II. Other significant conditions contributions	ing to death but not resul	ting in the ur	nderlying cause	given in Part I.		23e. Did tobac		o the cause of death?
II Kecora	The law ete has b page 2 sl	Completed							24a. Was an autopsy performed 1 Yes 2 🖔	prior to death?	utopsy findings available completion of cause of
DIVISION OF VITAL	r Attending Physician: The death. rector: After this certificete by the funeral director, pag	ertification; To Be	Natural 5 Pending  Accident investigation	a. Date of Injury (Month, Day Year)	28b. Time of Intury	28c. lr	Other: 4 Nurs	28d.	Describe how		
	- 0	O	4 Homicide determined 286	e. Place of Injury - At hon building, etc. (Specify)					City or Town, S	State)	ural Route Number,
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	Medical	(Check only 2 Medical Exeminer: C	on the basis of examination of manner stated.	on and/or inv	estigation, in m	ny opinion, death	occurred at	the time, date	and place, and du	e to the cause(s)
•	+ 3 F 8		) Olm	cm	02-1 77	D	58303	3		ceember 21204	
8	· [		30. Name and address of person who completed the complete address of person who completed the completed th	e un Ga	01 10	Charl	1625	DW W.	J MD	21209	
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 2 0 20	32. Register's Signatu	110	South	ž.				

			For	State of Maryland	•		ental Hygier	1e 0.05	1. 1000
		_	State Registrar		Certificate of	Death	Reg. ft	6.000	→ I U U O
A.	Physicia	an	1. Decedent's Name (First, Middle, Last)	В				19 2005	3. Time of Death  3. 10 QM
\$ .	/Medic	al	4a. Fecility Name (If not institution, give s.	treet and number) ; n	4b. City, Town,	or Location of Death		4c. County of Deal	
H	Examin	er	Good Samar tan	Horn tal	Balt	HIMD RA	0	N/	A
	Funeral		5. Social Security Number 6. Sex	M 2 F	Months   Davs	r If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Yea 02/20/19	9. Birt Cc	hplace (State or Foreign
100	Director		219-40-0761 1XI Usuel Residence of Decedent	M 2LIF 61	Yrs.		02/20/19	44 Est	onia
	land ow		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Mary Meritary	tor	Maryland N/A	Ba	ltimore				1√ Yes 2 No
	ith the	Directo	10e. Street and Number		10f. Zip Code			Citizen of What Co	•
	s 23a	rai	5116 Belair Road	Apt D  2. Was Decedent Ever in U.S.	21206	Hispanic Origin? (Spe		ited Sta	
	ter de	Funerai	11. Marital Status  1 Never Married 2 Married	Armed Forces?		Hispanic Origin? (Spe ban, Mexican, Puerto I	Rican, etc.)	Black, Whit	
93	rat', o	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give 1965 Year or Dates: 1968	to 1□Yes 2□XNo	Specify:		Specify: 1.1	hite
21215-003	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occu (Give kind of work don- life, DO NOT use retir	e during most of worki	ng 16b.	Kind of Business	Industry
121	within ene. then	duic	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+) 2 Years	Constructio	,		Construc	tion
ם ס	be filed within 72 hours after death with the Marylan tall Hygiene.  Ide Hygiene.  Ide other than "natural; or ttems 23a or 28a-f show other than "natural; or ttems caust be multified at event, the Madical Examinat caust be multified at	0	17. Father's Name (First, Middle, Last)				(First, Middle, Maid		<u> </u>
/lar	should be filed within 72 hours after death with the Maryland nd Mantal Hygiene. Is marked other then "natural", or items 23e or 28e-f show is marked other then "natural", or items 25e or 28e-f show umatic event, the Medical Examinar mant be multified at	To B	Johannes Kiik			Elsbet	Katti		
Maryland	2 sho and is ma raum		19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Stree				
	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any Injury or other traumatic ance.		Mai Kiik-Gelnett  20a. Method of Disposition	- Daughter	2200 Whitcom co of Disposition (Name of netery, crematory or other pi		Parkville Pate 20c.	Location - City or	234 Town, State
altimore,	Pages nent of int: # h		1 ☐ Burial 2 【XCremation 3 ☐ R.  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	top_Service_C	1 40 /0/	1/2005 <sub>T</sub>	owson. M	arvland
a E	permit. Pag Department Important: I any Injury o		21. Signature Function Function License	Charles F. Mi	ner 22. Name and Add			Harford	
<u> </u>	88 E 8 8		chaf I w		Leonard J	. Ruck, In		more, MD	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	e cause on each line.	Do not enter the mode of dy	ring, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metaltatic	Rectal	Cancel	2.		
P	Examiner			ACD Rat	ion Phei	Cancer mon;	3		
3		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque					
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8760,	death certificate be executed attending physician and of for use as the burial-transit	icai Ex	1030Amg in dodain, 2001	Due to (or as a conseque	silve oi).				
687	ficate physis the								
ŏ	death certific attending pl	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregnand		icv		23d. Date of de	,
0.0	e deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of dea 9 Unknown		,		Month	Day Year
<u>α</u>	The law requires that the de ate has been signed by the a bage 2 should be detached f	Phy	Part II. Other significant conditions cor	itributing to death but not result	ting in the underlying cause of	given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
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Vital Record	s been si should	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Re	The la	E O					performed 1 ☐ Yes 2 ☑	?   death?	2 No
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ot o	Physic this c	J.	1 ☐ Yes 2 OKNo  27. Manner of Death		Proutpatient 3 DOA		me 5 🗌 Residence 28d. Describe how in		ecify)
O	ding Ih. Th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury W	ork? □Yes 2□No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	Atter er dea ector by the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, offic	e	28f. Location (Street City or Town, St		ural Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai		sician: To the best of my know ner: On the basis of examination and manner stated.					
	fo the within. Fo the	Med	29b. Signature and title of certifier	anna mariner delitera		nse number		Date signed (Mon	
			Mark'nel	CM.D.	D6	3382		2/14/2	2005 moll, MD
	27		30. Name and address of person who co	impleted cause of death (Item:	23a) (Type, Print) 56 0	LLock Ra	ven Blod	Balti	niall, MD
	<i>y</i>		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	2123	9			
	St: Regist	ate rar	DEC 2 0	2005	A fine				

		1	For State Registrar	State of Maryland		artment of H			giene	1.1000
ı	Physici	_	Decedent's Name (First, Middle, Last)	Moris Louise				2. Date of Dea Month		3. Time of Death 8:05 A
	/Medic Examin		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, o	or Location of (		4c. County of Dea	
	Funeral		Genesis Heritage Me 5. Social Security Number 6. Sex 216-16-3199	7. Age (In yrs. la	care C est birthday) Yrs.	tr. Du  If Under 1 Year  Months Days		Hrs. 8. Date of Birt Min. (Month, Day Feb. 1	Baltimo	thplace (State or Foreign buntry)
	Director	-	Usual Residence of Decedent	81	170.			reb. 1.	Mar	yland
	yland		10a. State 10b. County	10c. City,	Town or Lo					10d. Inside City Limits
	e Mar	ctor	Maryland Balt	imore		Du	nda1k			1 ☐ Yes 2 ☒ No
	vith th	Dire	10e. Street and Number 22 Kinship Road			10f. Zip Code	21222		10g. Citizen of What Co	•
	eath v	era		. Was Decedent Ever in U.S	S. 13. V	Was Decedent of I	Hispanic Origin	n? (Specify Yes or No-	United Sta	
920	s 1 and 2 should be filed within 72 hours atter death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, it is Nedical Exam, ear must be notified at	by Funeral Director	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2X No		n? (Specify Yes or No- Puerto Rican, etc.)	Black, White Specify: White	
5-0036	72 hou	Completed	15. Decedent's Educa (Specify only highest grade of	tion		lent's Usual Occu kind of work done		of working	16b. Kind of Business	/Industry
2121	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, I a Med	m ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	nd)			
	Hygier Hygier Ther ti	S	10 Years 17. Father's Name (First, Middle, Last)		Tele	phon <b>e</b> Op		s Name (First, Middle,		ephone Co.
Maryland	d be f	To Be	Vernon Stehling					ouise Hink		
ary	shoul ind Me ind Me ind mari	۲	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Stree			er, City or Town, State,	Zip Code)
Ž	and 2 alth a 27 to er trai		Mr. John R. Keys (S	on)	307	Adair St	reet	Unit C-1 D	ecatur, GA	30030
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	CO	ace of Dispo metery, crer	sition (Name of matory or other pla	ice)	Date	20c. Location - City or	Town, State
Ë	Pag tment tant: I		* 4 ☐ Donation 5 ☐ Other (Specify)	Mean				2/20/2005	Dorsey, N	Maryland
Ball	permit. Pages 1 and 2. Department of Health ar Important: If Item 27 4s any injury or other trauging.		21. Sign fure of Furbani Service Licensee	Kally	Du 7		Funera Ave. I			
п			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each/line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ATHERO.	SCL	EROTIC	CCA	1 KD10 VA	SEASE	
	Examiner			Due to for as a conseque	ence of):	5146	,	DI	SEASE	
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, ,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a consequ	encé of):					
8760,	cate b physic the b	dlcal	d.	AKEMIA						
.O. Box 6	that the death certific: ed by the attending pl detached for use as t	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3[	Ectopic pregnand Other (specify)	ey		23d. Date of de Month	livery Day Year
0	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditions contr	ibuting to death but not resu	Iting in the u	nderlying cause g	ven in Part I.	23e. Did to	obacco use contribute t	the cause of death?
rds	w requires that been signed to should be det	ed b					-	101	fes 2□No 3□P	robably 4 Donknown
Division of Vital Records,	e law has b	omplet						24a. Was autop perio 1  Yes		utopsy findings available completion of cause of
/ita	ysician: Th is certiticate director, pag	Be	25. Was case referred to medical examiner?				- 4	of Death (Check only o	nne)	
of \	× ∞ 0	은	1 □ Yes 2 □ No		ER/Outpatier	it 3 DOA		,	dence 6 Other (Spe	ocify)
no On	ling After tune	:lol	27. Mann of Death Natural 5 ☐ Pending and Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wd	nryat ork? ]Yes 2√ZNo		low rijury occurred	
ivisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely tilled in by the tune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, str				Street and Number or R vn, State)	ural Route Number,
	pital ours a eral C	Ce	29a. Certifier 1 Certifying Physic	cien: To the best of my know	uladna daat	h occurred at the t	ime date and	place, and due to the	cause(s) and manner a	s stated
	24 ho Eun Fun	ledical	(Check only 2 Medicel Exemine one)	r: On the basis of examination and manner stated.	ion and/or in	vestigation, in my	opinion, death	occurred at the time,	date and place, and du	o to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)
•	1		Scotlinger la	- Sulla	MD	1)2	27/8	8	12/18/	05
	H		30. Name and address of person who com	ipleted cause of death (Item	YON	Print)	10/1	Dienstell	2 MO	2/222
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEG 2 0 20	32. Registrar's Signat	ure de	barles				

		•	For State Registrar	State of Marylan		artmen rtificate			ınd M		giene	005	1010
1 19 2	Physici	an	Decedent's Name (First, Middle, Last	DOROTHY		VI	EIN			2. Date of Dea Month DECEMBE		20 <sup>Y</sup> 035	3. Time of Death 10:27 PM
	/Medio	al	H 4a. Facility Name (If not institution, give					Location o		DECELIE		ounty of Deatl	
	CAUTI		GREATER BALTIMORE			If Under	TOWS	SON If Under 2	DA HEO			BALTIM	
	Funeral Director	0	5. Social Security Number 6. S  2/2-78-/386  1  Usual Residence of Decedent	ex 7. Age (In yrs.	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day 06/02/1	920	9. Birti Co.	hplace (State or Foreign untry) MA
	ryland		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	the Ma	Director	MD BALTIM	ORE BA	LTIMOR	E 10f, Zip	Code				10a. Citize	en of What Co	1 Yes 2 No
	h with	ai Di	1 SLADE AVENUE	APT. #706			208				-	.S.A.	
)36 <sup>/</sup>	hours after death with the Maryland lural', or Itema 23a or 28a-f show al Frencian must be notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2  No If Yes, Give X Year or Dates:		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White pecify: WH	
21215-0036	na 172	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usua kind of wo DO NOT us	rk done d	uring most	of working	g	16b. Kind	of Business/	Industry
212	d with giene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM		,					HOME	
Maryland	should be filed nd Mental Hygid marked other umatic event, II	To Be (	17. Father's Name (First, Middle, Last) FRANK		COFF			ETTA	\	(First, Middle,			KLINE
Mar	2 L L B B L L B B L L B L B L B L B L B		19a. Informant's Name/Relationship (			-				Route Numbe	-		(ip Code) MD 21208
	Hea Hea ther		20a. Method of Disposition	20b. I	Place of Disponentery, cre	sition (Nar	ne of	-		ate		ation - City or	
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	) HAR	SINAI					/2005	OWIN	GS MILI	_S, MD
Bai	permit. Pag Department Important: eny injury o		21. Signature of Fluneral Service Licer	/		2. Name an			้รกเ	LEVINS	ON &	BROS.	, INC.
	Physician		23a. Part1. Enter the disease, or conshock, byhear/failure. List only Immediate Gause (Final disease or condition	plications that caused the deal one cause on each line.	th. Do not en		1 T	erstu - O	W Rack	OBBratory at 1 C	ZKES.	VILLE,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	01	0	0 i	27	ire'			
	g #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):								
30,	te be executed ysician and ie burial-transit	i Examine	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a consec	quence of):								
68760,	ficate by physical for the b	edlcai	•	d									
P.O. Box	Physician: The law requires that the death certificate be executed this certificete has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3[	∃Ectopic pr ∃ Other (sp					23	d. Date of deli Month	ivery Day Year
	quires that the signed by ald be detacted	by	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	ınderlying d	ause give	en in Part I.		23e. Did to			the cause of death?
Vital Records,	The law requir. ete hes been si page 2 should l	Completed										24b. Were au prior to death?	itopsy findings available completion of cause of 2 No
Vita	slcian: Th certificete irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only o			
of	g Physier this neral dis	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		DA Outury Work	4 1140		ne 5 Resid			cify)
sion	불목절	catio	1  Matural 5  Pending 2  Accident investigatio 3  Suicide 6  Could not b	1	Injury	М	10	res 2 🗆 l					*
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st	reet, factor	y, office		2	28f. Location (S City or Tow		Number or Ru	iral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical		nysician: To the best of my kniner: On the basis of examination and manner stated.									
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	Akday		296	c. License	number	ク		29d. Date	signed (Month	h, Day, Year)
		!	1020 ge 1	record		D-: ::	IJ1.	0/3	_		12/	16/2	2005
×	131		30. Name and address of person who GEORGE A  31. Date filed (Month, Day, Year)	BEDON MI	67	701	Noc	la	1 les	51.	Ba.	140 00	4.21204
	St: Regist	ate rar	DEC 2 0 20	37. Registrar's Sign	S An	and it							

CM05-08536 Please Type or Print in Black Indelible Indelible Ensure All Copies Are Legible.
Amend Item in Black Indelible Indelible Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene William Lowe III For State Registrar 1-Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Joseph Lowe, III Dec<u>ember</u> 17, 2005 15:56 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore City Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 8, 1962 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Maryland 1QM 2□F Yrs. 43 212-80-8785 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State •how r than "natural", or iteme 23a or 28e-f ehor the Madical Examiner must be natified at 1 ☐ Yes 2√No Glen Burnie Maryland Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21061 8001 Cross Creek Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Workerced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman Shipping other 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Brenda Faye Thompson William Joseph Lowe, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8001 Cross Creek Drive Glen Burnie, MD 21061 Brenda Thompson / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 22, 20c. Location - City or Town, State 20a. Method of Disposition rtment of Department of Important: If It any Injury or o 1 ☐ Burial 2 区Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Catonsville, MD Metro Crematory 22. Name and Address of Facility permit. 21. Signature / Funeral Service Licensee Kirkley-Ruddick Funeral Home, P.A. sauge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21061 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gunshot wound to torso Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Completed by Physician/Medical ettending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes 2 ☐ No 1XX npatient 2 ER/Outpatient 3 DOA Certification; To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural

to the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After thi death. I Director: A filled in by within 24 hours after To the Funeral Dire

905 A M 5 Pending investigation Subject was that 1 Yes 2 No Dec 17, 2005 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Balamore, MD 2700 block of rear alle Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

O.C.M.E.

State Registrar

+

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tashu Z Greenberg MO

wheers

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

December 18, 2005

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

ren

			For State Registrar	State of M	aryland		rtment o			nd Mer		ene 0 0	5	41012
	300		Decedent's Name (First, Middle, Last)								Date of Death Month		Year	3. Time of Death
	Physici /Medic		Victoria	May	I	eahey	7				ecember	19,200	05	2:15 P M
	Examin		4a. Facility Name (If not institution, give s				4b. City, To					4c. County		
	made of the		438 Grovethorn Road  5. Social Security Number 6. Sex		ne (In vrs I	ast birthday)	If Under 1		le Riv		Date of Birth			timore place (State or Foreign
- 1	Funeral Director			M 2DF	58	Yrs.		Days	Hours	Min.	Date of Birth (Month, Day, oril 2,	1947	Cou	yland
	D		Usual Residence of Decedent											
	anylar ehow	2	10a. State 10b. County		,	, Town or Lo								10d, Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Directo	Maryland   Baltimore		Midd	le Riv	er 10f. Zip C	ode			10	g. Citizen of V	Vhat Cou	
	3a or		438 Grovethorn Roa	.d			10.1.0		21220			USA		.,
	death	Funeral		2. Was Decedent Armed Forces		S. 13. V	Vas Deceder Yes, specify			in? (Specify	/ Yes or No-	14. Race		can Indian,
36	or its	ру Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give			☐ Yes 20		Specify:	, , , , , , , , , , , , , , , , , , , ,	, o.o.,	Specify	,-	
Ö	ited within 72 hours after death with the Maryland Hygiene. Ither than 'naturel', or items 23a or 28a-f ehow ent, Ita Micalcal Examination notilied.	q pa	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Educ	Year or Dates:		16a Decer	ent's Usual (	Occupa	ation		1	6b. Kind of Bu	wn	
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212	giene giene er tha	E O	12	College (1-4or	3+)	Bond	Spec	cia	list			Insu	cance	e Company
D D	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)									laiden Sumam	θ)	
<u>\frac{2}{a}</u>	should be ind Mental I	2	Victor Jasensk  19a. Informant's Name/Relationship (Ty)			105 14-15-	- 4-1 //		May		Schill	Iarth City or Town,	Chara Ti	- Codel
<u>a</u>	d 2 st th and th sh traur		Donald M. leahey	(son)										a 22079
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. PI	ace of Dispo emetery, cren	sition (Name	of		Date		0c. Location -		
more, Maryland 21215-0036	Pages nent of I ant: If it		1 ♣ Burial 2 ☐ Cremation 3 ☐ R 4 ♠ Donation 5 ☐ Other (Specify)	emoval from State		dens c				2/22/0	)5 B	altimor	re Co	ounty Md
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Impartment of Health and Mental Hygiene. Impartment if item 27 is marked other than 'naturely, or items 23a or 28a-f ehow eny injury or other traumatic event, it a Modical Examinating mast he notified at once.		21. Signature of Funeral Service License		5							Funera ex Mary		
	7		23 . Part . Enter the disease, or complishook, or heart failure. List only on	cations that cau	d the death								Lanc	Approximate Interval Between
	Physician		Immediate Cause (Final dise or condition	m							11 Lu		A 1	set and Death
*	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):	- / VI			d. Lake		1	-	
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8760	ate be executed hysicien and the burial-transit	dicai												
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Вох	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic preg					23d. Dat Mor	e of deliventh	ery Day Year
o.	the d	ysic	1 ☐ Yes 2 € No 9 ☐ Unknown	9□ Unknown	01 30	,a.,, 5_	101101 (9,000	,						
ر. م	s that ned b e deta	by Pł	Part II. Other significant conditions con	tributing to death	but not resu	ılting in the u	nderlying cau	se give	en in Part I.		23e. Did tob	acco use contr	ribute to t	the cause of death?
g	w require been sig should b	ed b	BRAIN MET	957R54	<u> 28</u>						1 Ve	s 2□No	3 Prot	bably 4 Unknown
900	e lawre has be je 2 sho	Completed									24a. Was an	24b. V	Vere auto	opsy findings available ompletion of cause of
<u> </u>	The cate h	Соп									perform	ed? c	death?	
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ō	Attending Physician: r death. sctor: After this certifice by the funeral director.	. To	1 ☐ Yes 2 📉 No  27. Magner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of		. Injury Work	4 🗆 140			v injury occurr		fy)
0	nding I ath. r: After e funer	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	м		(? Yes 2 □ N	No				
Division of Vital Records,	For Attendiater death.  Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir building, e	ijury - At ho tc. (Specify	me, farm, str	eet, factory, o	office		28f.	Location (Str. City or Town,		er or Aura	al Route Number.
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funersi Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the bes er: On the basis and manner s	of examinat	wledge, death ion and/or inv	occurred at restigation, in	the tim	ne, date and pinion, deat	d place, and h occurred a	due to the ca at the time, da	use(s) and ma te and place, a	nner as s and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 /	/	1			number			d. Date signed		
•	4		Mon hurul 1	mus	wh	MO	0	33	55	/		12/2	0/0	)5
17	1		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print)	_			\(\rac{1}{2}\)		1	- /2 2 7
_			Michael HUERB		10 F	HILAD	elphia	/	0 #	314	BALT	make	2	21237
**************************************	Sta Registi		31. Date filed (Month, Day, Year)	n 200	rar's Signat	ure 0 0	A Charles	لعظ	7					

			1 - State of Maryland / Depar Registrar Certification	ificate of Death	Reg. N	. UUU	1013
	Physici		1. Decedent's Name (First, Middle, Last)  Naomi Lepson		Date of Death Month  CCember	16, 2005	3. Time of Death 12:00 A M
	/Medic Examin			4b. City, Town, or Location of Death  Dundalk		c. County of Death  Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 93 Yrs.	If Under 1 Year   If Under 24 Hrs.   8	Date of Birth (Month, Day, Yea 2D. 5, 1	9. Birthr	vace (State or Foreign vtry) Yland
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		1	0d. Inside City Limits
	8a-fsh	Director		Perry Hall			1 □ Yes 2 No
	3a or 2		10e. Street and Number 9507 P Kingscroft Terrace	10f. Zip Code 21128		Citizen of What Coul  U.S.A.	itry ?
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, I'n Medical Examinat must be notilised at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Naver Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica □ Yes 2 [X] No Specify:		14. Race - Americ Black, White, Specify: Wh	etc.
15-0	n 72 h "natu edical	ojetec	(Specify only highest grade completed) (Give kii	nt's Usual Occupation ind of work done during most of working O NOT use retired)	16b.	Kind of Business/In	dustry
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and	ould be filed Mental Hygin arked other atic event, I	Be	17. Father's Name (First, Middle, Last)  Adam Ditchler	18. Mother's Name (Fi		,	
aryl	s i and 2 should be Health and Menta tem 27 is marked other traumatic ex	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Re	oute Number, City	y or Town, State, Zip	•
	and n 27 er ti		Thomas Varholy, Sr. (son-in-law) 9507			ry Hall, N Location - City or To	
Baltimore,	t. Pages tment of rtant: If i		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. I		5 Bal	ltimore, N	laryland
Ba	Departiment of the particular			705 Belair Rd., Bal			
	Physician /Medical Examiner	er	resulting in death)  Due to (or as a consequence of):	the mode of dying, such as cardiac or re	DENT		Approximate Interval Between Onset and Death
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s, P	w requires that I been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the und	derfying cause given in Part I.	23e. Did tobacce	o use contribute to t 2 ☐ No 3 ☐ Prob	ne cause of death?
Vital Record		Completed			24a. Was an autopsy performed?	prior to co death?	psy findings available impletion of cause of
Vita		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (C		6 Other (Special	w)
J Of	ding Phye	on; To	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)		. Describe how in		9)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	M 1 Tyes 2 No  et, factory, office 28f.	Location (Street City or Town, Sta	and Number or Rura ate)	d Route Number,
_	e Hospital 24 hours e Funeral letely filled	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the death of t				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	Day, Year)
•	, _		Savinder 16 Julia MD	D 27/88	12	4/16/05	
(	5 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	29c. License number  D 27188  rint)  Med Place Den	delk.	MD 21	2-22
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 2 0 2005  32. Redistrar's Signature	carle			

			1 - State Registrar	State of Maryla	_	artment of I			giene	5 41014
	Physici	an	1. Decedent's Name (First, Middle, Last	-				2. Date of De Month		3. Time of Death
	/Media	cal	IRVIN LEVI			4h Cihi Taura	and another of D	12	18 2	005 12 45 4M
	Examir	ier	4a. Facility Name (If not institution, give JEWISH CONVALESCE			4b. City, Town, o		eath .	4c. County o	TIMORE
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 h	in. 8. Date of Bir (Month, Da	+h	Birthplace (State or Foreign Country)
	Director		217-16-7664 1) Usual Residence of Decedent	<sup>™ 2□ F</sup> 81	Yrs.	Monard Buyo	Tiodio it	1/11/1	924	MD
	yland iow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	MD N/A		BALTIM	ORE				1√ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
	s 23a		2500 W. BELVEDER	E AVE. APT.  12. Was Decedent Ever in		21215	Jianania Origin?	(Casaity Van as Na	U.S.,	A . e - American Indian,
920	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show ta Madical Espoirer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1 Wayes 2 No If Yes, Give Year or Dates:	1	was Decedent of the life Yes, specify Cub		(Specify Yes or No lerto Rican, etc.)	Black Specify:	k, White, etc.
21215-0036	"neturel",	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most of	workina	16b. Kind of Bu	siness/Industry
121	Jwithin 72 ho jiene. r than "netur in e Medical	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		CITY OF	DALTIMODE
	Hygi ther int.		17. Father's Name (First, Middle, Last)		ELEC	TRONIC TE		Name (First, Middle,		BALTIMORE
Maryland	e 6 2 5	To Be	OSCAR		LEVI	NE	BESSI	E		HOFFMAN
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Number	er, City or Town, S	
	s 1 and 2 should if Health and Mer item 27 Is marks other traumatic		RUTH LEVINE / WI		2500 b. Place of Dispo		EDERE AV	/E. APT#10		IMORE, MD 21215
Baltimore,	Pages 1 tent of h nt: If ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State 01	IEB <sup>mete</sup> SHAL	patory or other pla UM	<sup>Ce)</sup> 12,			City or Town, State STOWN, MD
Ħ			' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	ME	MORIAL	PARK 2. Name and Addre				
B	permit. Departr Importe any inju		Robert 10	7			_	SOL LEVINS I ROAD - F		LE, MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the d ne cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	end 8	tave D	ementa				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					
		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con:	sequence of):					
i.	te be executed ysician and ie burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
90,	oe exe cian a ourial-t	I Ex	resulting in death) Last	Due to (or as a con:	sequence of):					
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Вох 6	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date	a of delivery
	death le atte ed for	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnanc Other (specify) _	y 		Mon	
P.O	that the de ed by the detached	Phys	9 Unknown	CONTRACTOR PROFESSION				1		
Vital Records,	es be	ed by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	/en in Paπ i.			bute to the cause of death? 3 ☐ Probably 4 ☑ Únknown
900	law requir as been s 2 should	Completed						24a. Was	an 24b. W	Vere autopsy findings available rior to completion of cause of
Ä		Сош						perfo	rmed? de	eath?
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		C#		Death (Check only o		
of	Phys this ral di	n: To	1 Yes 2 VNo	28a. Date of Injury	28b. Time of	IL 3L DUA	4 Mursing	g Home 5 Resid	dence 6 Othe	
ion	Attending I ir death. ector: After by the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	) Injury		rk?  Yes 2 □ No			
Division	in Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (5 City or Tox	Street and Numbe vn, State)	r or Rural Route Number,
	e Hospital 24 hours a e Funerel I letely filled		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge deati	occurred at the ti	me, date and pla	ace, and due to the	cause(s) and man	iner as stated
	the Hos hin 24 h the Fur npletely	edical	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my	ppinion, death or	ccurred at the time,	date and place, ar	nd due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	NA.		29c. Licens	e number			(Month, Day, Year)
•	Λ		> EW UARD (	LH 171)		D6	317	4	12/17	7/05
	7		30. Name and address of person who co	- 1	0 . 1	Print)	Rai	to. M	A	
	Sta	te	31. Date filed (Month, Day, Year)	E 10441		) !	1 3 C	(0, 1-1	CV,	
	Registr		DEC 2 0 2005	Barren A	K Acco	K)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.U . Decedent's Name (First, Middle, Last) 2 Date of Death Physician A. GENEVIEVE MCLEAN DECEMBER 17, 2005 10:00 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SUNRISE MORNINGSIDE ASS'T. LIVING ANNE ARUNDEL HANOVER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F Director 006-12-3158 83 2Ś, 1922 MAINE Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MARYLAND ANNE ARUNDEL HANOVER 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7548 OLD TELEGRAPH RD. 21144 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: KOREA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) REGISTERED NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH CONNORS GEORGIA ROSS ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY GIANFORTE / DAUGHTER 917 MERRIWEATHER WAY, SEVERN, MARYLAND 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State
4 □ ¶onation 5 □ Other (Specify) DEC. 23 NEW HAMPSHIRE ST. VETERANS CEMETERY 22. Name and Addre 2005 BOSCAWEN, NEW HAMPSHIRE of previous Licenses 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 9 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ALZHEIMER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1111NG Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death,

To the Funerei Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title occrtifier 157531 DECEMBER 19, 2005 M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veg 8601 VETERANS HWY., SU. 204, MILLERSVILLE MD 21108 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

			. For	State of Ma		/ Depa	artment	of He	alth a			_	11016
		1	State Registrar			Cei	tificate	of De	eath			LW0.042	41010
	Physici		1. Decedent's Name (First, Middle, Last		1 :	-1				l N	ate of Death	Day 17. 2005	3. Time of Death 7:53 P M
	/Medic	al -	Laura Rebecca Pr		TTHOVS	sky_	4b. City, To	own. or Lo	ocation of		cember	4c. County of Deat	
	Examin	er	Charlestown Care					onsv				Balti	
	Funeral	-	5. Social Security Number 6. Se	x 7. Ag	e (In yrs. las	st birthday)	If Under 1	Year			ate of Birth Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign
	Director		273-42-3303	]M 2X1 F	91	Yrs.	1,10,14.10	54,5	1100.0	<u>J</u> i	ıly 16	, 1914 Inc	liána
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Maryl	to	Maryland Baltimor	ce		Cator	nsvill	е					1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number		<del>-1</del>		10f. Zip C	Code			100	g. Citizen of What Co	ountry?
	23e c	aiD	709 Maiden Choice					2122				USA	
	ar dez	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decede If Yes, specif	nt of Hisp fy Cuban,	anic Orig Mexican,	jin? (Specify , Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, Whit	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 X If Yes, Give Year or Dates:	INO		1□ Yes 2l	No No	Specify:			Specify: W	nite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or iteme 23e or 28e-f show other then "naturel", or iteme 23e or 28e-f show event, the Medical Evari we must be notified at	ted	15. Decedent's Edi (Specify only highest grad	ucation		16a. Dece	dent's Usual kind of work	Occupation	on ring most	of working	16	6b. Kind of Business	/Industry
218	ithin 7 nen r Ned	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	oo Not use eacher	retired)	mg moot			Dublic Scl	nool System
121	e filed within al Hygiene. I other then ' vent, the Me		17. Father's Name (First, Middle, Last)	4			eacher		8. Mother	r's Name (Fir		aiden Sumame)	NOOL System
anc		To Be	Henry Hayden Pre	scott								ine Everi	tt
ary	# B E E	F	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address (	Street and	d Numbe	r or Rural Ro	ute Number, (	City or Town, State,	Zip Code)
ž	교육시章		William E. Malin	ovsky, So						_		ryland 210	
ore	ges 1 at of He If Item or oth		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □	Removal from State	20b. Pla		osition (Name matory or oth			Date		Oc. Location - City or	
E	nit. Pag bartment cortent: I injury c		1 ☐ Burial 2 ☑ Cremation 3 ☐  • 4 ☐ Donation 5 ☐ Other (Specify		Met			-		12/19/			, Maryland
Baltimore,	permit. Pages 1 and Department of Heali importent: If Item 2 any injury or other once.	n n	21. Signature of Funeral Service Finomas Gregor	7		Ĉi 29	remati 99 Fre	on Solderic	ocie ck R	ty Of load Ba	Maryla Itimor	nd Inc. e, Maryla	nd 21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that cause one cause on each I	d the death. ine.	Do not en	ter the mode	of dying,	such as	cardiac or res	piratory arres	st,	Approximate Interval Between Onset and Death
	Priysician	K 19	Immediate Cause (Final disease or condition resulting in death)	a	DEM	ENTI	A						4EARS
	/Medical Examiner		resulting in death)	Due to (or as	s a conseque	ence of):							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a conseque	ence of):							
	outed Id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
,092	sician and burial-transit		resulting in death) Last	Due to (or as	s a conseque	ence of):							
6876	cate b	dicai		d									
	that the death certificate ed by the attending physi detached for use as the I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnan							23d. Date of de	livery
Box	death e atter d for u	iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pre Other (spe					Month	Day Year
P.0	at the by the tache	hys	9 Unknown	9□ Unknown									
	g g	b	Part II. Other significant conditions of	ontributing to death	but not resul	lting in the u	ınderlying ca	iuse given	ı in Part I.	.			o the cause of death?
Records,	w requir been si should	Completed									24a, Was an	24h Were a	utopsy findings available
Rec	sician: The law certificate has b irector, page 2 s	mpi									autopsy perform	ed?   death?	utopsy findings available completion of cause of
Vital		a	25. Was case referred to medical						26. Place	of Death (Cf		□ No 1 □ Yes	S ZZNIVO
ί	> 0 0	To B	examiner? 1 ☐ Yes 2 ██No	Hospital: 1 Inpat	ient 2 🗆 E	R/Outpatie	nt 3 🗆 DO	A Other	4 <b>20</b> Nu	irsing Home	5 Residen	nce 6 Other (Spe	ecify)
0 1	ding Ph After th funeral		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury		Bc. Injury a Work?			Describe how	w injury occurred	
Sio	Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not be		niuny - At hor	me farm st	M factory		es 2 🗆 l	-	Location (Stre	eet and Number or R	ural Route Number.
Division of	after Direction by	Certification;	4 ☐ Homicide determined	building, e	etc. (Specify,	)	ieet, iactory,	011100			City or Town,		
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the bes niner: On the basis and manner s	of examinati	vledge, dea ion and/or in	th occurred anvestigation,	at the time in my opir	, date an nion, dea	nd place, and th occurred a	due to the car t the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and little of certifier	and manners	nialeu.		29c.	. License	number		29	d. Date signed (Mon	th, Day, Year)
	F \$ F 8		Muno	/ N	_	MI	, 7	D49	470	48	$\mathcal{D}$	ECEMBE	< 18,2005
	DY		30. Name and address of person who	completed cause of	death (Item	23a) (Type		1 1 2					
1	0		MATTNEW	1. NAR	RET	7	709	Mai	den	Choi	ce La	ne Balti	more, MD
1	St Regist	ate	31. Date filed (Month, Day, Year)  DEC 2 0	200	rar's Signat	ure	1.0						
	ricgio	Tell	NEU & U	LUUJ C	Carle 1	6							

DHMH 17 Rev 1/2001

ORIGINAL

			State o	f Maryland / Dep <i>Ce</i>	ertificate of L		ental Hygier	21115	41017
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		Lois Shirley	McNa	mara		December [	17, 2005	7:00p M
}	/Medic Examin		4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, or	Location of Death		4c. County of Deatl	1
	ZX		Future Care Cherrywood		Reister	stown		Baltimore	2
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign
	Director		059 <b>-</b> 18-7809	83 Yrs.			Aug. 24,		sylvania
	w w	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	daryl f sho	ō	Maryland Baltimore	Baltimor	e				1 ☐ Yes 2 No
	the 288-	Directo	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
	3e or	Ö	8721 Windsor Mill Road		21244			USA	
	death ms 2	Funeral	11. Marital Status 12. Was Dece	edent Ever in U.S. 13.	. Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame	
9	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23e or 28e-f show atto event, the Medical Evantratoral be notified at	T.	1 Never Married 2 Married 1 Yes Gi	2 (TINO	1 ☐ Yes 2 ☐ No	Specify:	nican, etc.)	Black, White	
္က	ours iral',	d by	3 ☐ Widowed 4 🏝 Divorced If Yes, Giv Year or D	ates:				711	nite
2	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e <i>kind of work done c</i> DO NOT use retired	during most of working	ng 16b.	, Kind of Business/I	ndustry
12	within ane. then	E D	Elementary/Secondary (0-12) College (1	-4or 5+)		"	77	1	
2 2	filed Hygie ther ant,	ပိ	12 17. Father's Name (First, Middle, Last)	Dog	Breeder	18. Mother's Name	(First, Middle, Maid	ennel Jen Sumame)	
an	d be ental ced o	To Be	Anson Marshal	1		Marie	H	ughes	
Maryland 21215-0036	2 should be filed within 72 hours atler death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show attreed other than "natural" or Itemstic event, Ite Medical Exactifier read the notified at	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street				ip Code)
	and 2 ealth a n 27 Is		James M. McNamara (Son)	8721	Windsor	Mill Rd.,	Baltimor	e, MD 212	44
Baltimore,	- T 0 =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Disp	ematory or other plac	(6)	ate 20c.	Location - City or	Town, State
Ĕ	Pages nent of I ant: If its ary or o		1 ☐ Bunal 2 ☐ Cremation 3 ☐ Hemoval from 1 ☐ Donation 5 ☐ Other (Specify)	State Baltimore Loudon	Cremator	y @ 12/20	/05 Ba	ltimore,	Maryland
a	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee		22. Name and Addres				
_	90 F 9 9				620 Wilke			, MD 2122	
			Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e	aused the death. Do not er each line.	nter the mode of dyin	ig, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	fnysician		Immediate Cause (Final disease or condition resulting in death)	4/2/eca	es 1	11200	20		
К	/Medical Examiner		Due to	(or as a consequence of):	I at	Rrive			
Н		<u>~</u>	Sequentially list conditions, b. Due to	or as a consequence of:	-	(10-0			
	uted	Ë	Sequentially list conditions, Cause. Enter Underlying Cause (Disease or injury	VIDLO	210				
Ć.	ate be executed hysician and the burial-transit	Examiner	that initiated events c. Due to	(or as a consequence of):	4				
8760,	cate be ex physician the buria	dical	d						
9	rtifica ng ph	Jed	IE FEMALE:						
Вох	death certifics e attending pt id for use as ti	an/I	23b. Was decedent pregnant 23c. If yes, out		☐Ectopic pregnancy	,		23d. Date of deli	very Day Year
o.		Physician/Me	1 Yes 2 No		Other (specify)				
<u>م</u>	by ac	Ph)	Part Other significant conditions contributing to d	eath but not resulting in the	underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	uires tha signed I Id be det	d by	Parancia 100	Geitze	,		1 ☐ Yes	2 No 3 Pro	babiy 4 Unknown
20	w requir	ete	Chanic Lan	Jun 1	0 100	James d	24a. Was an	24b Were au	topsy findings available
Vital Records,	The lav	Completed		1, 101 (11		· Ome	autopsy performed	prior to death?	ompletion of cause of
a		a)	25. Was case referred to medical			26. Place of Death	(Check only one)	1 ☐ Yes	2 No
		To B	examiner?	Inpatient 2 ER/Outpatie	ent 3 DOA Oth	20	ne 5 Residence	6 ☐Other (Spec	ufv)
0	g Physier this		27. Manner of Death 28a. Date	of Injury 28b. Time		y at 2	28d. Describe how in	njury occurred	,,
Ö	ttendin death. ctor: Afr / the fur	atio	2 Accident investigation	,,,,,		Yes 2□No			
Division of	I or Attending I after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place build	of Injury - At home, farm, s ing, etc. (Specify)	street, factory, office	2	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	urs af rrel D								
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) (Check only one) (Check only one)						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	nor stateg.	29c. Licens	e number	29d. l	Date signed (Month	, Dey, Year)
	F 3F 9		I Nel Bles	nlore	nix	7 53	1	2/19/6	of
r	To a		30. Name and address of person who completed cause	se of death (Item 23a) (Type	e, Print)	, , )	171	11	Λ Λ
1	) .		4000012	1 2000	1.50%	< 300 i	11 resu	Alle 5	regland
	Sta		31. Date filed (Month, Day, Year) 327 F	Registrar's Signature	. 49 -				8
	Registi		COOL O COOL	200 SS 199					
DH	IMH 17 Rev 1/2	001		7					

**ORIGINAL** 

			For State Registrar	State of Mary		artment of F		Mental Hygien	CUU.	41018
	·		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month D	av Year	3. Time of Death
	Physici /Medic		Francis G. McFar					ECEMBER :	16, 2005	
1	Examin		4a. Facility Name (If not institution,		ando man	4b. City, Town, o	r Location of Death		c. County of Dea	imore
			Saint Joseph  5. Social Security Number		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		nthplace (State or Foreign
i,	Funeral Director		217-18-9010	1X514 00 5	34 Yrs.	Months Days	Hours Min.	June 15,19	7 1 6	timore, MD.
			Usual Residence of Decedent					,		
	nylan how	_	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	8e-1 (	ecto		nore County	Lutherv			140-0	· · · · · · · · · · · · · · · · · · ·	
	with the or 2 be or 2	D I	10e. Street and Number 105 Gothard Road	ı		10f. Zip Code	21093		itizen of What C	
	ns 23	Funeral Directo	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.			-	Jnited S	
0	be tiled within 72 hours atter death with the Maryland Hygiene. Hygiene. de thyligher de other than "natural", or items 23a or 28e-f ehow event, the Medical Examinat must be notified at	Fun	1 Never Married 2 Marrie	Armed Forces? d 1∆ Yes 2 □ No		Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Whi	
ğ	rai', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	J.W.II	1 ☐ Yes 2 E No	Specify:		Specify: \	<i>h</i> ite
2	72 h "natu	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occup kind of work done	during most of worl	king 16b.	Kind of Business	s/Industry
12	within ane. then	dm	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		<i>DO NOT use retired</i> etrical Er	•	7	Vestingh	201100
0 0	Hygi Hygi other	o C	17. Father's Name (First, Middle, La		Пісс	CLICAL III		e (First, Middle, Maide		louse
altimore, Maryland 21215-0036	should be tiled within of Mental Hygiene. marked other than imatic event, the M	To Be	James M. McFarla	ınd			Mary C.	McGee		
ary	es 1 and 2 should b of Health and Ment I Itam 27 le markec r other treumatice	Ī.,	19a. Informant's Name/Relationshi		- /	-		ral Route Number, City		
Σ.	and and a nath na 27 in 27 in er tre		Mrs.Carmen G.(ne							
ore	Pages 1 nent of He int: if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	DR Ctate		matory or other place	ce)		_ocation - City or	
E	: Pag tment tent: jury		4 □ Donation 5 □ Other (Spe	ecify)		· ·	1	.21,05 Time	nium,Ma	ryland
Ba	permit. Page Department Importent: It eny injury o		21. Signature of Funeral Service Li	F. Jave,	Dr. 2	2. Name and Addre Peaceful A 2325 York	Alternati Road Ti	ves Funeral monium, Man	&Cremat	ion Ctr.,P.A 1093
			23a. Raw1. Inter the disease, or c shock, or heart failure. List of	omplications that caused the nly one tause on each line.						Approximate Interval Between
¥	Physician		fmmediate Cause (Final disease or condition	a ANOXIC E	ENCEPHAL	OPATHY				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
10		- G	Sequentially list conditions, if any, leading to immediate	b. CARDIOFU	JLMONAR'	Y ARREST				
	ted insit	Examiner	cause. Enter Underlying Cause (Disease or injury			my m 1 /				
o,	exection and and rial-tra	Еха	that initiated events resulting in death) Last	c. CARDIOGE Due to (or as a co	onsequence of):		**			
8760,	The law requires that the death certificate be executed the has been signed by the ettending physicien and sage 2 should be detached for use as the burial-transit	dicai		d. MYOCARDI	IAL INF	ARCTION				
9 xo	eath certific ettending p for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of de	elivery
m.	death e etter d for i	iclar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		□Ectopic pregnancy □ Other <i>(specify)</i> _	<i>'</i>		Month	Day Year
0	that the de led by the e detached f	hys	9 Unknown	9∐ Unknown						
	res tha igned be det	by F	Part II. Other significant condition	s contributing to death but no	ot resulting in the u	underlying cause giv	ren in Part I.			o the cause of death?
2 d	w require been sig should b	ted						1 Tes	2 <b>2</b> No 3 □ P	robably 4 Unknown
ec	has be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>								performed? 1 ☐ Yes 2 N	death? 1 ☐ Ye	s 21 No
<u>=</u>	siciar certit recto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	• C = D = 0 · · · ·	nt 3 DOA Oth	ar.	th (Check only one)	- Co	
ō	Attending Physician: The Ir death. ector: After this certificete he by the funeral director, page	-	27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	III 30 00A	4   14613111g 1 h	ome 5 Residence 28d. Describe how in		ecity)
<u>o</u>	nding ath. r: Afte e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		ear) Injury		rk? Yes 2 □No			
Division of Vital Records,	= 00>	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - building, etc. (5		reet, factory, office		28I. Location (Street a City or Town, Sta	ind Number or P	Rural Route Number,
٥	ital or rs atte rel Dir led in	Cer								
	To the Hospital or At within 24 hours after of To the Funeral Direct completely tilled in by	edical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best of m xaminer: On the basis of exa and manner stated.	amination and/or in	th occurred at the tir nvestigation, in my o	me, date and place, ppinion, death occur	and due to the cause( red at the time, date a	s) and manner and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	P 101	1	29c. Licens	e number	29d. D	ate signed (Mon	tr Day, Year)
•			1 mile	Jow /1	. ()	n a	4034		2/17	105
	10+1		30. Name and address of person w	no completed cause of death	(Item 23a) (Type		y ent tony 1		1	1
	10''		31. Dale filed (Month, Day, Year)	1 = 1.7 = 2. Hegistrar's	SLER DR	IVE TOW	SON MARY	4 AND 212	24	
	Sta Registi		31'. Dale'filed (Month, Day, Year) DEC 2 0 20	2. Pegistrar's	Signature	160				
4.	- region		DE0 % V 20	UU Ray FRA S	C. Distance					

				1 - State Amend Item Registrar	State of 1 23b per p	Marylar h <b>y</b> G8	nd / Depa 50 12-2	rtment o	of He	alth and I eath	Mental Hy	giene Reg. No.2	005	41019
		di ki		Decedent's Name (First, Middle, L.							2. Date of Dea	ath		3. Time of Death
	*	Physici /Medi			rose						12		2005	2:10PM
	4	Examir	ier	Franklin Squ	C - 11		ital	4b. City, To	own, or L	ocation of Death	1	60	unty of Death	imore
		Funeral Director				Age (In yrs.	last birthday) Yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 30	, 1915	9. Birth	place (State or Foreign intry) Land
		ō.		Usual Residence of Decedent		10- 0	· +				, , , , , , , , , , , , , , , , , , , ,			
		Marylar f show	jo	10a. State 10b. County  Maryland Baltime	ore		ty, Town or Loc Lddle Ri							10d. Inside City Limits 1 ☐ Yes 2 1 1 1 2 1 2 1 1 2 1 2 1 2 1 2 1 2 1
		death with the Maryland irms 23a or 28a-f show ir reust be notified at	Funeral Director	10e. Street and Number				10f. Zip Co	ode 21220	)		-	of What Cou	intry?
9		eath v	eral	929 Wampler Road	12. Was Decede	ant Ever in I	IS 13 W				pecify Yes or No		Race - Amer	ican Indian
5	980	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Exartinar naist be notified at	þ	1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Force	ss? ☑ No		Yes, specify		Mexican, Puert	pecify Yes or No- o Rican, etc.)		Black, White ecify: Whi	, etc.
0	2-0	72 ho	eted	15. Decedent's (Specify only highest of	Education		16a. Deced	ent's Usual C	Occupati	on ring most of wor	kına	16b. Kind o	of Business/li	ndustry
2	121	within and than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Homema	O NOT use	retired)			∩wn	Home	
Rose, Mas	Maryland 21215-0036	d be filed within ntal Hygiene. ed other than:	Be	17. Father's Name (First, Middle, La: Ernest Ermer	st)		Tionene	ANCE		8. Mother's Nan Anna Kl	ne (First, Middle, .egal			
20	aryl	2 should be and Mental Is marked o	5 C	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (S	Street an	d Number or Ru	rai Route Numbe	er, City or To	wn, State, Zi	p Code)
-		and 2 lealth a m 27 ls		Darla Smith (Dau	ghter)					ad, Bal	timore,			
8	Baltimore,	0 0		20a. Method of Disposition †⊞Burial 2 ☐ Cremation 3		v.a.	Place of Dispos cemetery, crem	atory`or othe	er place)	nd Dog	17 200E1		ion - City or T	
2	Iţim			4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie		HO								Maryland
کے	Ba	permit. Departr Imports any inji				>	1.	407 01	Bri d Ec	izdzinsk Istern A	i Funera venue, l	al Hom Essex,	e, P.A Maryl	A. Land 21221
				23a. Part1. Enter the disease, or co shock in heart failure. List on	mplications that cau by one cause on eac	sed the dea h line.								Approximate Interval Between
4		Physician	8 /	Immedia Cause (Final disease a coordion resulting in death)	_a CAD									Onset and Death
		/Medical Examiner		resulting in death)	Due to (or	as a conse	quence of): Non-ST	-Segme	ent I	Elevatio	on Myoca:	rdial	Infar	ction
	**	美。"这个	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for	as a conse	quence of):							
		be executed ician and burial-transit	Examiner	Cause. Either Orldarying Cause (Disease or injury that initiated events resulting in death) Last	. ASP11	ati		neu	SMJ	nía				
	60,	ate be exe nysician a he burial-	icai Ex	resulting in deathy cast	Due to (or	as a conse	quence of):							
	687	ficate g phys	edic		d			• • • • • • • • • • • • • • • • • • • •						
	Box 68760,	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregi	nancv			23d.	. Date of deliv	*
	P.O. B	or Attending Physician: The law requires that the death certificate be executed titer death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of		Other (speci					Month	Day Year
	۹.	es that the deigned by the be detached	by Ph	Part II. Other significant conditions	contributing to deat	h but not re	sulting in the un	derlying caus	se given	in Part I.	23e. Did to	obacco use o	contribute to	the cause of death?
	ords	w require been sig should b	ted b								1 🗆 1	res 2□N	o 3 🔽 🕫	bably 4 Unknown
	ecc	e 2 sh	Completed								24a. Was autop	SV	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
	alF	n: The licate har, page			1						1 ☐ Yes	rmed? 2 No	1 Yes	2 □ No
	Ĭ.	yaician: ] is certificat director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Np	atient 2	☐ ER/Outpatient	3□ DOA	Other		th <i>Check only</i> o		Other /Snec	60
	J Of	ding Phyaician: h. After this certific funeral director,		27. Manner of Death	28a. Date of I (Month,		28b. Time of		: Injury a Work?		28d. Describe			19)
	sior	uttendin death. ctor: Afi y the fur	catic	1 ☐ ¶atural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ion			М	1 🗌 Ye	s 2 No				
	Division of Vital Records,	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	4 Homicide determine	A 286. Place of	Injury - At h , etc. <i>(Spec</i>	nome, farm, stre	est, factory, o	office		28f. Location (S City or Tox		umber or Rui	al Route Number,
		To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basi and manner	s of examin	owledge, death ation and/or inv	occurred at estigation, in	the time.	, date and place nion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as	stated. to the cause(s)
		o the	Med	29b. Signature and title of certifier	and manner	Stated.		29c. L	License r	number		29d. Date si	gned (Month	Day, Year)
		7		1 XXX	0	_				5517	1	12	113/	5
		15		30. Name and address of person wh	o completed cause	of death (Ite	m 23a) (Type, I	Print)	~ /	0.00	1.		10 D	21237
	*	n contra		31. Date filed (Month, Day, Year)	hn 4000 F	istrar's Sign	511n Sc	mor	el	1 Ba	TIMO	19,	INDO	X125/
		Sta Regist	áte rar			o oigii	Es A	Lech !						

Ramola Martin 05-8418 AJK

			For State 1 - State Registrar	te of Marylan		artment of Heal rtificate of Dea		ntal Hygier	- 000	41020
	Division		Decedent's Name (First, Middle, Last)				2.	Date of Death Month	Day Year	3. Time of Death
	Physici /Medio	tal		Martin		r		ecember	13, 2005	7:49 A M
>	Examin	er	4a. Fecility Name (If not institution, give street a			4b. City, Town, or Loca			4c. County of Death	1
			Howard County General  5. Social Security Number 6. Sex	Hospital 7. Age (In yrs.	last hirthday)	Columbia		Date of Birth	Howard	place (State or Foreign
	Funeral Director		n/a		Yrs.		ours Min.	(Month, Day, Ye	ar) Cou	ndia
	σ		Usual Residence of Decedent							
	arylan how	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cafion				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	s within 72 hours after death with the Maryland liene. r than "naturel", or Items 23a or 28e-f ahow I'n Medical Examinat must be rodified at	Director	Maryland Howard		<u>E1</u>	licott City	<u> </u>	40-	0.00	
	with ti		10e, Street and Number			10f. Zip Code		109.	Citizen of What Cou	antry ?
	eath	erai	8303 Grove Road  11. Marital Status 12. Wa	s Decedent Ever in U	S 13	21043		Yes or No-	India  14. Race - Amer	ican Indian.
<b>,</b>	r Item	Funeral	1 Never Married 2 Married 1 □	ned Forces? ]Yes 21∑No	1	Was Decedent of Hispan If Yes, specify Cuban, Me		an, etc.)	Black, White	
21215-0036	el', o	ğ	If Y	es, Give 22 ar or Dates:		1 ☐ Yes 21 No Sp	ecify:		Specify: Asia	an-Indian
5	72 hg	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	16b	. Kind of Business/li	ndustry
121	within ene. then "	mp	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	life.					
			17. Father's Name (First, Middle, Last)			n/a	Mother's Name (F	irst, Middle, Maid	n/a den Sumame)	
Maryland	d be ental ked o	To Be	Steve Leonard	Martin			Bina	Chiman1a		ncholi
ary	AS DE E	-	19a. Informant's Name/Relationship (Type, Pri		19b. Maili	ng Address (Street and N				
	1 and 2 Health a lam 27 le		Steve & Bina Martin/p	arents	8303	Grove Road	Ellico	tt City	, Marylan	d 21043
altimore,			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Remova		Place of Dispo cemetery, crea	sition (Name of matory or other place)	Date	20c	. Location - City or T	Town, State
Ë	Pages ment of ant: If it ury or o		4 Donation 5 Other (Specify)			del Cremato			Odenton, 1	
Balt	permit. Page Department of Important: If any Injury or		21. Signafure of Funeral Service Licensee	MOC	)957   <sup>22</sup> 1	2. Name and Address of 1 Donaldson Fu 411 Annapol	Facility Ineral Ho is Road	me & Cre	ematory, l	P.A. d 21113
			23a. Part Senfer the disease, or complications shock, or heart failure. List only one cause	that caused the deat	th. Do not ent	er the mode of dying, suc	ch as cardiac or re	spirafory arrest,		Approximate Interval Between
	Enysician:		Immediate Cause (Final disease or condition	He	od	Inju	neu			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):	6,				
и	Lxummer	-	Sequentially list conditions, b.	Due to (or as a conseq	meinea off-					
T	ted nsit	n in	cause. Enter Underlying Cause (Disease or injury		, au					
V	execun n and ial-tra	Examine	that initiated events c.	Due to (or as a conseq	quence of):			_		
58760,	icate be executed physicien and s tha burial-transit	edicai	d							
	S to to	Med	IE EEMALE.						1	
Box	eath certifi attending for use as	any	230. Was decedent pregnant	es, outcome of pregna ]Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of deliver Month	very Day Year
P.O. E	The law requires that the death certified has been signed by the attending tage 2 should be detached for use a	Physician/M		Pregnanf at time of d Unknown	death 5	Other (specify)		suvenousimeses	Monar	oay roa
	that the		Part II. Other significant conditions contribution	ng to death but not res	sulting in the u	nderlying cause given in	Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	w requires been sign should be	ed by						1 ☐ Yes	2 No 3□Pro	bably 4 Unknown
000	aw rens bee	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available
Ä	The Late has page	E						performed	l? death?	ompletion of cause of 2 No
Vital	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26.	Place of Death (C	neck only one)		
of V	Physic this co	၉	1√3Yes 2 No Hospita	1 □ Inpatient 2 <u>K</u>	NER/Outpatier				6 ☐Other (Spec	ify)
n C	ther.	<u>o</u>	1 □Natural 5 □ Pending	. Dafe of Injury (Month, Day Year)	28b. Time o	Work?	200 F	. Describe how i	njury occurred	+- 1.21
Division	death death ctor: / the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e	Place of Injury - At h	Ome farm st	-	281	Location (Street	and Number or Rui	ral Boute Number
Δ	effer effer Direct	Certification:	4 Homicide determined	building, etc. (Special	1 1th	nt.	8	City or Town, S		21043
	To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A complately filled in by the fo	Medical C	29a. Certifier (Check only only)  29b Medical Examiner: O					due to the cause		
	To the within 2 To the complat	Mec	29b. Signature and title of certifier	2amin 3/4/50.		29c. License nun	nber	29d.	Date signed (Month	. Day, Year)
	r>r0		* () Churley M			O.C.M.E	Ε.	Dec	cember 14,	, 2005
_	h		30. Name and address of person who complete	d cause of death (Iter		Print)				
	3		JUARUN WEKE	IND		Penn Street	, Baltimo	ore, Mar	yland 21	201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature .	10-				
	Regist	rar	DEC 2 0 2005	Alagre .	La A			<del>_</del>		

		-	For State Registrar	State of Maryland / Department of Health and Men Certificate of Death	ntal Hygien	1 20 4 600
	Dhysisi		Decedent's Name (First, Middle, La.	st) 2.1	Date of Death	3. Time of Death
	Physicia /Medic	al		a street and number)  4b. City, Town, or Location of Death	December	
	Examin	er	4a. Facility Name (If not institution, giv	P. d. Liv. da /K	*	Da Himore
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 1	Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	M 201F 4/ Yrs. Some Sylvenia	Month, Day, Yea	914 Nebraska
	ylend how		10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	he Ma	ecto		nore Dundalk	10- 0	1 ☐ Yes 2 ☑ No
	a or 2	Funeral Director	10e. Street and Number	Road 21222	log. c	USA
	eme 2	inera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Hys, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian, Black, White, etc.
36	filed within 72 hours after death with the Marylend Hygiene. yther than "natural", or Iteme 23a or 28e-f show yth, I're M-circal Examinar must be mailfied at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specity: Year or Dates:		Specify: WK, te
5-003	72 hou natura lical E	ted	15. Decedent's E. (Specify only highest gra	16a. Decedent's Usual Occupation (Give kind of work chare during most of working	16b.	Kind of Business/Industry
2121	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	D	tomatica MG
2	Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last,	Clerical 18. Mother's Name (Fin		tomotive 111tg.
/lan	Mental Mental arked atic sv	To B	Edward =	Tones Edna	Crocie	R
Maryland	12 sho h and 7 Is ma treum		19a. Informant's Name/Relationship (	Type, Print) 19b. Mailing Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip Code)
_	Healt Healt Hem 2		20a. Method of Disposition	20b. Place of Disposition (Name of Date	1 N 95 V 1	Location - City or Town, State
E O	Pages nent of ant: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Special	JRemoval from State	05 B	altimore, md
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiane. Importent: If Item 27 is marked other than "natural; or Iteme 23a or 28e-f show any injury or other treumetic svent, It a Modified at ODE.		21. Signatur Funeral Service Licer		FUNERAL VING K	Home, P.A.
	-		23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardiac of recone cause on each line.		Approximate Interval Between
	Physician	ě 10	Immediate Cause (Final disease or condition resulting in death)	Arteriosclerotic Cardiovascular	Diseas	Onset and Death  10 YE CAS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		
7	2 =	ner	Sequentially list conditions, if any, flagging to intimediate cause. Enter Underlying Cause (Disease or injury that initiated average.	b. — Sue to (or as a consequence of):		
/	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):		
68760,	ficate be executed physician and s the burial-transit	edicat E		d.		
	intificating physes as the	Medi	IF FEMALE:			
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy    Live birth   2   Fetal death   3   Ectopic pregnancy    4   Pregnant at time of death   5   Other (specify)		23d. Date of delivery  Month Day Year
P.O.	the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		
	res that igned b	by	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
ord	w require been si should I	eted			1 Tes	
Vital Records,	he law e has l age 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ital	sicien: The lav certificate has rector, page 2	Be C	25. Was case referred to medical examiner?	26. Place of Death (Cl	1 ☐ Yes 2 N heck only one)	lo 1 Yes 2 No
of <	Physicien: r this certificanal director,	၉	1 Yes 2 No 27. Manner of Death		5 X Residence Describe how inj	6 Other (Specify)
O	ding I th. : After s funer	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year) Injury Work?	. Describe flow an	dry occurred
Division	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	200. Flace of injury - At nome, fami, street, factory, once	Location (Street a	and Number or Rural Route Number, te)
	spitel			nysician: To the best of my knowledge, death occurred at the time, date and place, and		
	ths Ho nin 24 th the Fu	Medical	one)	miner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.		
L	To vith	2	29b. Signature and Aftle of certifier	DEDUTY D18667	1	late signed (Month, Day, Year)
	10	<	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	1020	1
	10		Philip Militelly		lary lan c	21093
	Sta Regist		31. Date filed (Month, Day, Year)  DFC 2. 0_2	32. Registrar's Signature	,	
			ULU 6. U 6.			

			For State Registrar	riease			nd / Depa		of H	ealth and Moeath	•		005	41022
	* D	4	1. Decedent's Name								2. Date of De			3. Time of Death
	Physic /Med		Vernon J			h 1		4h City T	************	Location of Death	DEC		6 20	05 62 AM
	Exam	iner	4a. Facility Name (I	St Agni	es Ito	sprita		B	PLTII	YOKE If Under 24 Hrs.			. County of E	
	Funera Directo		5. Social Security N 213-30-13		Sex I⊠M 2□F	7. Age (In yrs.	last birthday) Yrs.	Months Months	Days	Hours Min.	8. Date of Bi (Month, D 04-1-	1933	Ma	Birthplace (State or Foreign Country) ryland
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Maryl Fe sho	ţō	MD	Baltimo	re	Ha1	ethorpe	е						1 ☐ Yes 2 X No
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "neturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at	al Director	10e. Street and Nur 5113 Arbu					10f. Zip ( 2122				10g. Ci	itizen of Wha	t Country?
	of ner mus	Funeral	11. Marital Status	ied 2K Married	12. Was Deced	2 🔀 No	į.			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	Black, V	American Indian, White, etc. White
	DO3(	d by	3 Widowed		If Yes, Give Year or Da	tes:		1 Yes 2		Specify:			Specify:	
į	715-1	Completed		15. Decedent's E	ducation a <i>de completed)</i> College (1-	.4or 5+)	16a. Dece (Give life.	edent's Usual e kind of work DO NOT use	k done d e retired,	ition uring most of work	ing	16b. F	Kind of Busin	ess/Industry
	212 ad with giene ger tha	Com	Elementary/Seco				Truck	Drive	r			1		tation
	/land utd be file Mental Hy wrked oth	To Be	17. Father's Name William						A	18. Mother's Name Ignes Abe		a, Maidei	n Sumame)	
	Mary ind 2 sho alth and 1 27 Is ma		19a. Informant's N Frances							nd Number or Rur ve. Hale				te, Zip Code)
	Baltimore, Maryland 21215-0036 sernit, Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "neturel", or any injury or other traumatic event, the Medical Exam			position □Cremation 3 [ 5 □Other (Speci		. !	Place of Dispondering completely adowright	matory or oth	her placi	al 12-1	9-2005			y or Town, State
	Baltil permit. I Departm Imports any inju	No.	21. Signature of Fu	-	1	2				s of Facility Ineral Ho Iur Sprin				
	£ 6.		23a. Part1. Enter t shock, or hea	he disease, or con int failure. List only	aplications that ca	used the dea ich line.								Approximate Interval Between Onset and Death
	Physician /Medica		Immediate Cause disease or condition resulting in death)	(Final on	a	Į.	ung	ca	MC	in				Unknow
	Examine		Convention line on	adiisaa 📗	b 60 60 60	or as a conse	quence oi/							
X	Pg is	lner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to (	or as a conse	quence of):							
*	760, te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death)	5	CDue to (	or as a conse	quence of):							
	2 2 0	dlcal		•	d									
	Box leath cert attendin	Physiclan/Medl	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2( 9 ☐ Unknown	months? □ No		rth 2 ☐ Fet ant at time of	al death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date of Month	delivery Day Year
Z	Records, P.O. The law requires that the dense been signed by the	by	Part II. Other signi		contributing to de	ath but not re	sulting in the t	underlying ca	use give	en in Part I.		/		te to the cause of death?
2	COLC w requi been s	leted									24a. Wa			e autopsy findings available
_>		Completed									auto	opsy ormed?	prior deat	r to completion of cause of
4	Vita ician: sertific ector,	Be	25. Was case reference examiner?		Hospital:	/			Othe	26. Place of Deat				
20	Of Physical	1: To	1 Yes 2		N/A	npatient 2 [ of Injury h, Day Year)	28b. Time of		Bc. Injury	4   Nursing no	ome 5 Res 28d. Describe			Specify)
12	Oivision or Attending after death. Director: After in by the function	atlo	1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not I	on	n, Day rear)	Injury	М		res 2 □ No				
Mary	DIVIS all or Att	Certification:	3 Suicide 4 Homicide	determined	28e. Place	of Injury - At I ng, etc. (Spec	nome, farm, si ify)	treet, factory,	, office		28f. Location City or To			or Rural Route Number,
5	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exe	hysician: To the miner: On the ba and mann	isis of examin	owledge, dea ation and/or i	th occurred a nvestigation,	at the tim	ie, date and place, pinion, death occur	and due to the red at the time	e cause(s	s) and manne ad place, and	er as stated. due to the cause(s)
	To the To the Comp	×	29b. Signature and	title of certifier		P				06362	5	29d. Da	ate signed (A	fonth, Day, Year)
	10		30. Name and add			-	em 23a) (Type	, Print)	1)	06362 WE BA			1	
		itate	A annw 31. Date filed (Mon	otherna oth, Day, Year)		GNES egistrair's Sign				WE ISA	LTIMOR	LE	MO	21229
	Regi			DEC 2	0 2005	Bluery	w St.	Sport	Sis.					

			1 - For State Registra <u>Amend</u> Iter								ental Hy	C 0 0	5 1	+102	3
			Hegistrafile III Tel     Decedent's Name (First, Middle		r rn Go	))I M	<u> </u>	AH.			2. Date of Dea			3. Time of	Death
н	Physici		Barbara D.	Menefee							Decembe	er ¹i̇̃7, a	2ďď5	2:30	ам
	/Medio Examin		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City	Town, or	Location o	of Death		4c. County	y of Death		
			Multi-Medical	Center				Towso				Balt	imore	2	
	Funeral Director		<b>216<sup>al</sup> 69<sup>ri</sup>8996</b> ° 4 <del>68-03-064</del> 2	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	. last birthday) Yrs.	Months Months	Days	Hours	24 Hrs. Min.	8. Date of Birt (Month, Da larch I	13-13-19 2, 1943	Pe Birthp Cour Irε	olace (State of http: Land	r Foreign
	P .		Usual Residence of Decedent		100.0	ity, Town or Lo	antina							Od. Inside Cit	te Limite
	aryla show	-	10a. State 10b. County	•										1√∑Yes	-
	he M	ecto	Maryland N/	A		Baltimo		p Code				10g. Citizen of	What Cou		
	with	盲	6102 Greenspri	ηα Δνε				21209	i			USA		, .	
	ns 23	Funeral Directo	11. Marital Status	12. Was Dece	edent Ever in I	U.S. 13.				igin? (Spe	cify Yes or No- Rican, etc.)		ce - Americ		
ယ	or Itar		1 Never Married 2 Marri	Armed Fo	2 X No			erify Cubar 2 1 No			Rican, etc.)		ick, White,	etc. nite	
8	72 hours after death with the Maryland natural; or Itams 23a or 28a-1 show Jical Examinat must be notified at	d b	3 Widowed 4 Divorced	If Yes, Giv Year or D	ates:		1 1 105	241 NO	эрөспу.			Specia	y: W1.	1100	
21215-0036	d within 72 hours after death with the Marylan jiene. r than "natural", or Itams 23a or 28a-1 show Its Modeal Examiner met be notified at	Completed	15. Decedent (Specify only highes			16a. Dece (Give	dent's Usu kind of wo	ial Occupa ork done d ise retired)	tion <i>uring m</i> os	t of workin	ng	16b. Kind of E	iusiness/In	dustry	
12	within one one one one one one one one one on	du	Elementary/Secondary (0-12)	College (1	1-4or 5+)		take					Elde	r1y		
d 2	file Trys		17. Father's Name (First, Middle, I	Last)					18. Mothe	er's Name	(First, Middle,	Maiden Surnai			
an	d ta d	To Be	Kevin Done	gan					Bri	dget	J	ennings			
Maryland	E E E	-	19a. Informant's Name/Relationsh	nip (Type, Print)			-					er, City or Town			
	교육 등 급		Ashton Menefee	/ Son				ester	Roa			aryland			
altimore,			20a. Method of Disposition  1	3 Removal from	State	Place of Dispo cemetery, crea	matory or	other place			ate	20c. Location			
Ë	tant:		`4 □Donation 5 □ Other (S)		L	orraine			-	12/21	1/05	Baltim			
Bal	permit. Page Department o Important: If any injury or once.		21. Signatur of Fun Solvice I	Jonese /				nd Addres		-	llome '			k Road	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of	aused the dea	ath. Do not en	ter the mo	de of dying	, such as	cardiac o	r respiratory a	Inc.Tows	3011,111	Approximate	ө
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	each line. <i>EEM</i>	IA								Interval Bet Onset and I	ween Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):		4.5	4 -	1 4	ca 1.				
	Examine	_	Sequentially list conditions,	b	Or as a conse	AND C	170	NIC	Rin	1/2	1717 LL	IN			
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	14-8	ATO	En IAI	541	VARO	MEI	ACU:	TE TILR	IRE VAR a	FEIIM	06'5	
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	50010	(01 40 4 001100	44401.00 01).		2				<i></i>	- 1010	-01-	
8760,	ficate be executed physician and is the burial-transit			d. LIV	EN 1	STILL	NE	155	PST	5		_			
9	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	-32											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		oirth 2 ☐ Fe	tal death 3	⊒Ectopic p						ate of deliver onth		Year
o.	at the de by the a tached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	4⊟Pregr 9□Unkn	nant at time of own	death 51	Other (s	респу)							
Δ.	that the		Part II. Other significant condition	ons contributing to d	eath but not re	esulting in the L	nderlying	cause give	n in Part I	l.	23e. Did t	obacco use con	ntribute to t	he cause of d	leath?
rds	quires n sign uld be	d by	SEPSIS								1 🗆 🗅	res 2□No	3 🗌 Prot	oably 4 🗗	Inknown
CO	s been si	plete	TERMINAZ	- LAR!	1860	AL	CA	NC	EN		24a. Was	an 24b.	Were auto	ppsy findings a	available
of Vital Records,	The law cate has page 2 s	Completed										rmed?	death?	2 <del>2 N</del> 0	-
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							e of Death	(Check only o	ne)			
of V	Physician: r this certifica ral director,	ပု	1 ☐ Yes 2 ☐ No			ER/Outpatie			4 - N			dence 6 □Ot		fy)	
	ding F	on	27. Manner of Death  1 Natural 5 Pendin	9	th, Day Year)	28b. Time o	M	28c. Injury Work	rat t? res 2.⊟		280. Describe i	now injury occu	rred		
Division	or Attendi after death. Director: A in by the fu	ficat	2 Accident investig	not be	of Injury - At	home, farm, st						Street and Num	ber or Run	al Route Num	ber,
Ω	after d after d Direct d in by	Certification;	4  Homicide determ	build	ing, etc. (Spec	pify)		,,			City or To	vn, State)			
	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune	edical C	(Check only 2 Medical	ng Physician: To the Examiner: On the b	asis of examin										)
	o the ithin 2 o the explet	Med	one) 29b. Signature and title of certifie		iner stated.		29	c. License	number			29d. Date signi	ed (Month,	Day, Year)	
1	F 3 F 8		> File	lecho!	ms			BE	32	717	•	12/19	7/01		
/	5		30. Name and address of person			өт 23а) (Турө	, Print)	75	95	052	En s	on	( 4		
5			FERN AND SO	AB	26M	20		To	WS	ON	MD	2172	1		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	ASF.	keģistrar's Sig	nature	and a	ř.							

	1 - State of Ma	aryland / Department of Ho <i>Certificate of L</i>		gie <u>2</u> e0 05 4 102L
Physician	1. Decedent's Name (First, Middle, Last)	Nima	2. Date of De Month	Day Year
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. Cry, Town, or		BER 16, 2005 1:50 P M  4c. County of Death
Examiner	GREATER BALTIMORE MEDICAL	CENTER TO	WSON	BALTIMORE
Funeral Director	091-07-6430 <sup>1∑M 2□F</sup>	e (In yrs. last birthday)  93 Yrs. If Under 1 Year Months Days	Hours Min. 8. Date of Bi (Month, D. NOV • 1	orth ay, Year) 3, 1912 9. Birthplace (State or Foreign Country) New York
ow ow	Usual Residence of Decedent           10a. State         10b. County	10c. City, Town or Location		10d. fnside City Limits
a-f sh	MD Baltimore	Timonium		1 ☐ Yes 2 X No
or 28	10e. Street and Number	10f. Zip Code	1000	10g. Citizen of What Country?
a 23a	3 Brooking Ct.		1093	USA
d 21215-0036 filed with the Maryland Hygiene. The Table Transition of Italian 23a or 28a-1 show not, the Medical Exeminat must be notified at a Completed by Funeral Director	3 X Widowed 4 □ Divorced Year or Dates:	High Yes 2 No 13. Was Decedent of His Highest Specify Cubar	spanic Origin? (Specify Yes or No h, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White
21215-00 ed within 72 hor ygiene. Per then "naturu it, the Medical!	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	tion uring most of working	16b. Kind of Business/Industry
d 212 d 212 diffed with Hygiene and, the	3	Regional Insura	ance Manager	Zurich Insurance
S S S S S S S S S S S S S S S S S S S	17. Father's Name (First, Middle, Last)	7	18. Mother's Name (First, Middle	, Maiden Surname)
farylanc should be f should be	Peter Nigro  19a. Informant's Name/Relationship (Type, Print)	19h Mailing Address (Street a	Teresa Pippa	er, City or Town, State, Zip Code)
re, Maryla re, Maryla s 1 and 2 should Health and Mer tiem 27 ie marke other traumatic	Valerie Bigelow/Daughter		Ave. Hunt Valle	
	20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place Dulaney Valley	Date	20c. Location - City or Town, State
Baltimo permit. Page Depentment. Page Important: if any njury or once.	21. Signature of Funeral Service Licenses	Memorial Gardens		Timonium, MD aney Valley, Inc.
<b>©</b> 88558	Michael J. Flagl	e 10 W. Padon	ia koad Timoniu	m, MD 21093
	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limmediate Cause (Final	I the death. Do not enter the mode of dying ne.	, such as cardiac or respiratory a	Approximate Interval Between Onset and Death
Physician /Medical	disease or condition a.	a consequence of):		THE STATE OF THE S
Examiner	Sequentially list conditions.	a scleratic GARDIN	VAROLAR DISE	ASE YEAR
oxecuted executed ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits	a consequence of):		
58760, ireate be executed physicien and s the bural-transit	resulting in death) Last Due to (or as	a consequence of);		
68760, ifficate be ex g physicien as the burial edical Expenses	d			
OX 6	IF FEMALE: 23c. If yes, outcome	of pregnancy		23d Date of delivery
S, P.O. Box es that the death cert gned by the attending be detached for use a by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
cords, P wrequires that been signed to should be det		ut not resulting in the underlying cause give		tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 □Unknown
e la has			24a. Was auto perfo 1 ☐ Yes	psy prior to completion of cause of death?
Vital Fician: The certificate ector, pag	25. Was case referred to medical		26. Place of Death (Check only	
on of Vita ding Physician: After this certific funeral director,	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie		4   Indianid Liquid	
inding I	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	y Year) Injury Work	at 28d. Describe ? es 2 □ No	how injury occurred
Division c tel or Attending P is after death. el Director: After I ed in by the tuners	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	ury - At home, farm, street, factory, office c. (Specify)	28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
Divisic To the Hospitel or Attent within 24 hours after deat To the Funeral Director: completely filled in by the		et my knowledge, death occurred at the time examination and/or investigation, in my opinion.	e, date and place, and due to the inion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To th within To th comp	29b. Signature and title of certifier	29c. License		29d. Date signed (Month, Day, Year)
	topy of the	auc 0220	057	12/16/05
10	30. Name and address of person who completed earlies of d	eath (Item 23a) (Type, Print) GB	MC 6701 N. Towson,	Charles Street MD 21204
State Registrar	31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature		

ORIGINAL

State of Maryland / Department of Health and Mental Hygie $_0$  0 5 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 750 December Thomas Seymour O'Hare Sr. 17 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 199 03 7051 Director 26,1920 Balto.Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits worte ! r than "natural", or Itema 23s or 28s-f ahov the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13125 Miles Road 21220 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 X) Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) School Bus Baltimore County Driver permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event gone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) O'Hare Edward Joseph Theresa Agnes Mooney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Gibson (daughter) 13125 Miles Road Middle River Maryland 21220 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) New Cathedral Cemetery 12/21/05 Baltimore, Maryland 21. Signature of Furnaral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 E fter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on the fine. Imm diate Cause (Final diseas) condition resulting in death) Onset and Death ardiac Arrest **Physician** /Medical (Congestive Heart Failure) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 2X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death | Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Deptifying Physician: To the heat of my knowledge, death oncurred at the time, date and clade, and due to the mause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 17, 2005 AT2438946 Jopa Baen, D.O. ss of person who completed cause of death (Item 23a) (Type, Print) Basu, D.O. Union Memorial Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2005

ORIGINAL

			1 - For State of Maryland / Dep	artment of Health and Mertificate of Death	, ,	ene g. No.2 0 0 5	41026
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	Physicia		Elizabeth Carozza Oswald			Day Year 15, 2005	4:28 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			1328 Hollow Glen Court	Baltimore		N/A	
	Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day,	Year) Coi	place (State or Foreign intry)
L	Director	-	214-38-0824 71 Yrs.  Usual Residence of Decedent		May 26,	1934   Mary	land
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary Fish	ţō	MD n/a Baltimor	·e			1 ☐ Yes 2 ☐ No XX
	h the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	untry?
	th wit		1328 Hollow Glen Ct.	21226		USA	
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or fr	by Fu	1 ☐ Never Married 2 ☑ ★ parried 1 ☐ Yes 2 ★ INO If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify: Whi	ite	Specify: wh	ite
Ö	filed within 72 hours after death with the Maryland Hygiene. Hygiene. strens 23e or 28e-f show ther then "naturel; or items 23e or 28e-f show ent. It is Moderal Examination unit be molified at	ed be		edent's Usual Occupation	1	6b. Kind of Business/l	ndustry
Ç	in 72 in 72	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing		
212	r the	lmo	Elementary/Secondary (0-12) College (1-4or 5+) 4+ Homem	aker		Home	
פ		Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
/lar	should be filed with nd Mental Hygiene. s marked other the umatic event. It e.l.	To E	Eugene M. Carozza	Lucile M	McQuire		
ar <sub>2</sub>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is and Mental Hygiene is marked other then "naturel, or frems 23e or 28e-1 show is marked other then "naturel, or frems 23e or 28e-1 show terms the experiment of the Modical Experiment of the Modical Experiment.		7,7,7	ling Address (Street and Number or Rui			ip Code)
<u>₹</u>	and sealth m 27			Hollow Glen Ct. Ba			-
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other treumatic a once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	position (Name or ematory or other place) Park Cemetery Dec. 1	Date 2 19,05 B	Saltimore C	
Balt	permit. Departnimports eny inju		21. Signature of Funeral Service Liceptee	22. Name and Address of Facility Lou 3620 Wilkens Ave			
			23a. Party Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.				Approximate
	Physician <sup>*</sup>		Immediate Cause (Final	ama Mulhila	.00		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	sma Mary	MIT		8 menury
Н	Examiner			V			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physician and s the burial-transit	Examiner	that initiated events c.				
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8760	cate b	dical	d				
9	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	von.
Вох	atten for us	Physician/Me	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
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	res that the signed by be detact	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	quires n sign	d b	· Diabetes Mellitus		1 □ Ye	s 2□No 3□Pro	bably 4 Unknown
Vital Records,	s been s	Completed	· Hukertension		24a. Was ar		topsy findings available
Be	The la	mo			autopsy perform	ed? death?	ompletion of cause of 2 No
ta	ysicien: The law is certificate has t director, page 2 s	a)	25. Was case referred to medical	26. Place of Dea	th (Check only one		
	nysica nis ce direc	To B	examiner? 1   Yes 2   No	ent 3 DOA Other: 4 Nursing He	ome 5 Reside	nce 6 Other (Spec	sity)
0	ding Ph h. After thi funeral		27. Manne of Death 1 ☑Natural 5 ☑ Pending 28a. Date of Injury (Month, Day Year) 1 ☑Natural	Work?	28d. Describe hor	w injury occurred	
Sio	ttendii death. ctor: A y the fu	catl	2 Accident investigation	M 1 Yes 2 No			
Division of	or Att	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28t. Location (Str City or Town,	eet and Number or Ru , State)	ral Houte Number,
	pitel ours a eral (	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the ca	usa(s) and manner as	stated
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	rred at the time, da	ite and place, and due	to the cause(s)
	With To 1	Σ	29b. Signature and title of certifier	29c. License number	29	od. Date signed (Month	9 00 5
	8		1. Jam 11. D.	שואו בע	×	12/10/	~ 003
Û	)		30. Name and address of person who completed cause of death (Item 23a) (Type	uy, Suite 610, G	In Rive	mie Mi	21061
W.		to.	31. Date filed (Month, Day, Year)  32. Registrar's Signature	cy switch of	CONDU	ville j vill	121001
	Sta Regist		DEC 2 0 2005 Feeture & An	المنافعة			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2350 December John W. Oaks 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Campus Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**∑**(M 2□F 84 215-12-5401 Nov. Director 14. Maryland Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f ehow 1 ☐ Yes 2 No Director Maruland Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 21047 2300 Furnace Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Marned 0 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Engineer Beth Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine E. Steigerwald George H. Oaks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree once. 2300 Furnace Road. Fallston. MD 21047 Dean W. 0aks (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/19/2005 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Duen 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mucardial /Medical Examiner crongry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Heart 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Encephalo Anoxic 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Vinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Difte of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

John William

31. Date filed (Month, Day, Year) DEC 2 0 2005

29b. Signature and title of certifier

30. Name and address of person

32. Registrar's Signature

o completed cause of death (Item 23a) (Type, Print)

Bel Air, Maryland Marco Zamora, MO

29d. Date signed (Month, Day, Year)

December 16,2005

				Please	ype or Print					•		egible.	
				For	State of Mar	yland / De	partme	nt of H	ealth and	Mental Hy	giene	(3)	1 1000
				1 - State Registrar		C	ertifica	te of L	Death		Reg. No. U	05	4   028
				1. Decedent's Name (First, Middle, La	ast)		-			2. Date of De			3. Time of Death
	4.	Physic /Medi		MAUREEN C		NNELL				Month 12	16 Day	2005	- 2:45 AM
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		Funeral Director		147-24-8990	Sex 7. Age (	In yrs. last birthd 72 Yrs	Months		Hours Min.		h y, Year) 11933	9. Bin	thplace (State or Foreign Duntry)  SERSEY
		pug 👔 🔄		Usual Residence of Decedent  10a, State 10b, County		Oc. City, Town or	r Location						10d Incide City Limits
		death with the Maryland ma 23a or 28a-f ehow mass tea cotiling at	7	200									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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5	36	Irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 No	Specify:		Sp	pecify:	
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1				NOREEN A. O'	DUNNECK - DAU	WHITE 5	5033	5 PRI	VEHEUSE	Circle	= B	ALDM	ONE, MO 2123
1	ore	es 1 end of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Di	sposition (Na	me of		Date		tion - City or	
14	Ĕ	Pages nent of int: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		ARLIN	CEME	NATTON	VAC 27		ARLI	NETON	VA
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	m	Departmine Department of the police of the p		Malato.	15/1/1		8800	HAR	FORD 1	RO. F	ARKU	,11E V	m0 21254
				23a. Part1 Enter the disease, or con shock, or heart failure. List only	nplications that caused th	e death. Do not	enter the mo	de of dying	, such as cardia	c or respiratory ar	rest,		Approximate
		Physician		Immediate Cause (Final	- CHRONI	C - 1 10N	10- 1	CE A	~C .	o. d. c-			Interval Between Onset and Death
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アスト	68	certificate Iding phys	Physician/Medical	IF FEMALE:									
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-	ú	w requires that the death certificate been signed by the attending phys should be detached for use as the	by	Part II. Other significant conditions	contributing to death but r	not resulting in the	e underlying	cause give	n in Part I.				the cause of death?
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(-)	of	Physicien: Th this certificete al director, pag	2	1 ☐ Yes 25(No		2 ER/Outpa			4 🗀 Nursing F	lome 5 🗆 Resid	ence 6	Other (Spec	on Hospice
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	Division	or At fter o Yirect in by	Certification:	4 Homicide determined		- At home, farm, 'Specify)	street, factor	ry, office		28f. Location (S City or Tow		lumber or Ru	ral Route Number,
		pital urs a eral [		00.0.00									
		To the Hospital or Attanding Physicien: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	Physician: To the best of naminar: On the basis of examinar and manner stated	camination and/or	eath occurred r investigation	at the time n, in my op	e, date and place inion, death occu	e, and due to the dirred at the time,	ause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
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		11		30. Name and address of person who	completed cause of deal	th (Item 23a) (Tvr	pe, Print)		ر ,	-		10	204
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	Funeral		Social Security Number	Sex 7. Age	(In yrs. last bi	irthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Birt	h		
	Director		031-24-0286	1 <b>⊠</b> M 2□F	73	Yrs.	Months	Days	Hours	WIII I.	oct. Da	71932	Mas	nplace (State or Foreign untry) SSACHUSETTS
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Loc	cation							10d. Inside City Limits
	Mary Ined	tor	Md. Baltin	nore	Phoeni	Х								1 ☐ Yes 2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, If e Modical Examiner traumatic event, If e Modical Examiner traumatic event, If e Modical Examiner traumatics.	ai Director	10e. Street and Number 3812 Duddingto	n Way			10f. Zip (	211	31			10g. Citizen o	f What Cor	
	ams 2	inera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decede Yes, speci	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Amer lack, White	ican Indian,
36	s after	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		0		☐ Yes 2		Specify:			Spec		Mite
8	2 hour		15. Decedent's	Education	16a	. Deced	lent's Usual	Occupa	tion			16b. Kind of	Business/I	ndustry
215	thin 7: e. an "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)		kind of worl OO NOT use			t of workin	ig	T	4	
12	iled wi lygien har th	Con	17. Father's Name (First, Middle, La			rce	Pres			ar'e Namo	(First, Middle,		trial	
ylanc	ould be fi Mental H arkad ot atic evar	To Be	Charles Gregory	0'Connell					Bea	atric	e Beru	ıbe		
Baltimore, Maryland 21215-0036	. 1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship Mrs. Joanne O'Cor								oenix,			ip Code)
ore,	of He of He II item		20a. Method of Disposition 1 Darial 2 X Cremation 3	☐Removal from State	20b. Place o						ate	20c. Location	n - City or 1	Town, State
ţ	t. Pag tment tant: ijury d		' 4 ☐ Donation 5 ☐ Other (Spe	cify)	Hillto					12-20	-05	Tows	son, N	1d.
Bal	permit Depar Impor any ir once.		21. Signature of Funeral Service Li	censee		R	Name and Ruck T .050 Y	owso	on Fu	neral	Home,	Inc. 21204		
			23a. Part1. Enter the disease, or conshock, or heart failure. List of	omplications that caused by one cause on each lin	the death. Do e.									Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. pneuh										1 west
ı	Examiner		, and a second	Due to (or as a			Gara	50	ucon					20 months
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a					w) w/	)				
	ocuted nd transit	Examiner	that initiated events	с.										
760,	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a	i consequence	of);								
687	icate l physi	edical		d.										
Box (	death certifica e attending ph ed for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		h 2	Ectopic pre					23d. [	Date of deliv	very
B.	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (spe			-			<b>Nonth</b>	Day Year
P.0.	hat the	Phy	9 Unknown  Part II. Other significant condition	s contributing to death bu	t not resulting	in the un	nderlying ca	use dive	n in Part I		23e. Did to	bacco use co	ntribute to	the cause of death?
Vital Records,	The law requires that the tite has been signed by th bage 2 should be detache													bably 4 Unknown
Seco	e law r has be je 2 sh	Completed							-		24a. Was autop	an 24b sy rmed?	. Were aut prior to c death?	opsy findings available ompletion of cause of
a		e Col	25. Was case referred to medical						20 81	( D 1)	1 ☐ Yes	2 2 No	1 🗆 Yes	2□ No
		To Be	examiner?	Hospital:	nt 2 ER/O	utpatien	t 3 🗆 DO				(Check only one 5 Ansid		ther (Spec	(fv)
10	ng Phys ter this neral di	n: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b.	Time of Injury		Bc. Injury Work	at		8d. Describe h			,,
Siol	Attanding r death. actor: After by the fune	catic	2 Accident investiga 3 Suicide 6 Could no	t he			М		es 2 🗌					
Division of	al or At after d I Diract d in by	Certification:	4 Homicide determin			arm, stre	eet, factory,	office		2	City or Tou		nber or Hu	ral Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E.	Physician: To the best of caminer: On the basis of and manner sta	examination a	ge, death nd/or inv	occurred a restigation,	at the time in my op	e, date an inion, dea	nd place, a oth occurre	nd due to the	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date sign		
}	. 1		T. austin	Dogle in				D 2	380	9		Decem	ber 1	9, 2005
_	2017		30. Name and address of person w L. Aus HJ Doyle	no completed cause of de	eath (Item 23a)	(Type, I	Print) - Ofr,	, 22	5. (	reeue	, St-,	Briltino	7 / Y	ND 21201
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 0	2005 32. <b>Degistra</b>	r's Signature	La	all)							
					42	6								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registered Item #2 Per PHy G850 12/20/05 JH

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN A. POWELL 10-06 12/07/05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 8 N. KASSUTH STREET If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7 Age (In vrs. last birthday) 6 Sax (Month, Day, Year) 10 - 06 - 1927 **Funeral** 1 **Ø**M 2□ F 217.64.3002 18 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral', or iteme 23a or 28a-f ehow Exemper must be notified at NA Director MD BALTIMORE 10e. Street and Number 10f. Zip Code STREET 8 N. KASSUTH 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) mit. Pages 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural", or item Injury or other treumatic event, the Medical Exercation. 1 

M Never Married 2 

☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: δ 3 ☐ Widowed 4 ☐ Divorced

College (1-4or 5+)

NIA

Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 1H GRADE

Be

2

Examiner

Physician/Medical

ð

Completed

Be

2

Certification:

Medical

permit. Pages 1
Department of H
Important: If iter
any Injury or oth

**Physician** 

/Medical Examiner

attending physician and for use as the burial-transit

signed by the a Id be detached fo

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page 2 s

certificate

this

Director: After that in by the funeral

within 24 hours a To the Funeral I

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CONSTRUCTION WORKER

16b. Kind of Business/Industry CONSTRUCTION

17. Father's Name (First, Middle, Last) JAMES SMITH

MABEL PONIELL

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18. Mother's Name (First, Middle, Maiden Sumame)

MARGARET COATES 20a. Method of Disposition

2803 BARTOL AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE MD 21209 Date 20c. Location - City or Town, State

PIKESVILLE

Reg. No:

Day

4c. County of Death

10g. Citizen of What Country?

USA

14. Race - American Indian, Black, White, etc.

Specify: BLACK

NA

Birthplace (State or Foreign Country)
 AMICA

10d. Inside City Limits

1 KNYes 2 □ No

1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

DRUID RIDGE 12.15.05 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
RALIO: MO 2/229 22. Name and Address of Facility

21. Signature of Funeral Service Licens Vangh

5151 BALTO. NATE PIKE, BALTO. MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9□ Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No

Non

24a. Was an autopsy performe 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient

5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27 Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Principlane Care

29c. License number

G-KAKEMBO

30. Narrye and address of person who completed cause of death (Item 23a) (Type, Print) HENRY G-KAKEMBO / MD CLYBN. Luzene Av. Balt-

State Registrar 31. Date filed (Month, Day, Year) DEC 2 0 2005



DHMH 17 Rev 1/2001

ORIGINAL

Day

MD

Approximate Interval Between Onset and Death 2 Month

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown

1 Yes 2 No

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

			State of Maryland / Dep			2000 41001
			1 - State Registrar Amend Item #6 Per FH G850 1292  1. Decedent's Name (First, Middle, Last)	0/05 GHDI DeallI	Reg. 2. Date of Death	3. Time of Death
	Physici /Medio		ODELL W. PAYNE			DO5 Year 12:40 PM
7	Examir		4a. Facility Name (If not institution, give street and number)  5901 OLD FREDERICK ROAD	4b. City, Town, or Location of Death BALTIMORE		4c. County ol Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Ye	
	Director		Usual Residence of Decedent		08.19.190	3 VA
	ryland		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	he Ma	ecto	MD BALTIMORE CATONSVI			1 ☐ Yes 2 🕅 No
	With t	Funeral Director	5901 OLD FREDERICK ROAD	10f. Zip Code	10g.	Citizen of What Country?
	death	nera		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural; or itema 23a or 28a-f ehow imetic event, the Madical Examinar marke notified at	by Fu	1 Never Married 2 Married 1 Yes 2 20 No 3 22 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	rican, etc.)	Black, White, etc.  Specify: 12 1001
8	2 hour	ted t	15. Decedent's Education 16a. Dece	edent's Usual Occupation	. 16b	Specify: BLACK Kind of Business/Industry
21215-0036	vithin 7 ne. han "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		1 malana ()
8 7	filed w Hygier other tf		12 TH GRADE 6 YRS 1	EACHER 18. Mother's Nam	e (First, Middle, Maid	ALTIMORE CITY
Maryland	Abntal Mental rked o	To Be	EDWARD WATKINS	JESSIE		TERSON
lary	2 6 2 5		1 - 0	ing Address (Street and Number or Rur	al Route Number, Cit	y or Town, State, Zip Code)
	is 1 and 2 of Health item 27 other tra		EDWINA A. WATKINS (SISTER) 2811 20a. Method of Disposition 20b. Place of Disp		ALTO MD	21215 Location - City or Town, State
ğ	Pages nent of int: If it		16 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Commetery, cre  Commetery, c	ematory or other place)	200.	CESVILLE, MD
altimore,	permit. Pages Department of Important: If it any injury or c			2. Name and Address of Facility AUGHN C. GREENE FUN		
m ==	8988		Cangha 5	151 BALTO NATL PIKE,	BALTO, MD.	21229
			Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Approximate Interval Between Onset and Death
)	Pnysician /Medical		disease or condition resulting in death)  Due to (or as a consequence th):	he heart	ai ture	Zuns
	Examiner		Sequentially list conditions b	of clustic for	line	10900
	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	good to		
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_			IF FEMALE:			
Box	leath certifi ettending   I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	t the d by the eched	Physician/M	1 Tyes 2 No 4 Pregnant at time of death 5 9 Unknown			
S,	law requires that the death certif as been signed by the ettending 2 should be deteched for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacc	use contribute to the cause of death?
ecords,	w requir been si should				1 🗆 Yes	2 No 3 Probably 4 Unknown
Rec	The law ete has b page 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>ta</u>	hyeicien: The Is his certificete har I director, page 2	BeC	25. Was case referred to medical examiner?	26. Place of Deat	1 Yes 2 1 h Check only one	No 1 Yes 2 No
<u></u>	Attending Physician: or death. actor: After this certification in the funeral director.	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			6 ☐Other (Specify)
00	ding I Ih. After funer	tlon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident Investigation	DI 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division of Vital	Atten ar deal actor	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28l. Location (Street City or Town, Sta	and Number or Rural Route Number,
ā	urs after rei Dir					
	To the Hospital or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Medical Examinar: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, exestigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated.  Ind place, and due to the cause(s)
	To the To the Comple	Me	29b. Signature and little of pertifier	29c. License number	29d. [	Date signed (Month, Day, Year)
	_		M// Miscan Whican	in D2971	69	12/16/05
	30		30. Name and address of person who completed cause of death (Item 23a) (Type	5 6 M. Rollan	. 60 0	1/ 1/2/200
	Sta	te	31. Date liled (Month, Day, Year)  32. Registrar's Signature	J 101 - A (Cha	Ja mu	(the was al - 10
	Registr	ar	DEC 2 0 2005		•	

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Year PARKE December 1512005 0510 Edn 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death LUTHERAN NURSING HOME AUGSBURG LOCHERN BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yee 6. Sex Months 1 □ M 280 F 68 243.52.8071 'NC 03.01.1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No BALTIMORE GWYNN OAK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2930 FAIRVIEW ROAD 21207 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 No Specify: 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 VRS Elementery/Secondary (0-12) NURSE HEALTH CARE 12 1H GRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LYMAN HARDY CORA HOPKINS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) (DAUGHTER SHARAE PARKER 2930 FAIRVIEW RD., BALTO. MO 21207 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 12.22.05 OWINGS MILLS, MD 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee anghy 5151 BALTO. NATL' PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Due to (or as a consequence of): COLONG X Pars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1⊞ Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1⊠Yes 2□No 1 ☐ Yes 2 No 25. Was case referred to medical 26 Plece of Death (Check only one)

**Physician** /Medical Examiner The law requires that the death certificete be executed

Physician

/Medical

Examiner

10a Stete

MD

Director

Funeral

ģ

Be Completed

**Funeral** 

Director

ral', or items 23a or 28a-f Examiner must be notitie

Pages 1 end 2 should be filed within 72 hours after death with I ment of Health end Mentel Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be in

Baltimore, Maryland 21215-0020

the Merylend

Physician/Medical Examiner buriel-transit physician sthe buriel ettending j signed by the e Completed by certificete has been s irector, page 2 should or Attanding Physician: funeral director, Be Certification: To efter deeth Director: A 3 in by the f

Division of Vital Records, P.O. Box 68760,

Part II. Other significent condition	s contributing to death but r	not resulting in the underlying c	ause given in Part I.

			E0. 1 1000 01 D	call ( chook of h)
examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpetient 3☐ [	DOA Other: 4-Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Death  1   Natural 5   Pending  Pending investigat	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29b. Signature and title of certifie

29c. License number

037573

Decembe 15,2005

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Keiste stan MD 25 21136 7, Del1 Man 31. Date filled (Month Day Year) 32. Registrar's Signature

State Registrar

within 24 hours efter To the Funeral Dla completely filled in Hospital

edical

			1 - For State Registrar	State of M	arylan	d / Depa	artmen	t of H				giene	05	4103	3
	Physici	an	1. Decedent's Name (First, Middle, Last	")		9	PRice	E			2. Date of Dea Month	Day	17. 25	3. Time of D	eath 3/44
)	/Medic Examir		4a. Facility Name (If not institution, give	street and number			4b. City,	Town, or	Location o		VECENIE		County of De	ath	77.
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d	Funeral Director		218-60-7207	7. Ag	ge (In yrs. 52	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	Date of Birtl (Month, Day 4-20-	, <sub>Year)</sub> 53	9. B	orthplace (State or Country)  Md.	Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City	Limits
	Mary a-f eh	tor	Md. NA		]	Baltim	ore							1 X Yes 2	2 No
	or 28	Direc	10e. Street and Number				10f. Zip					10g. Citiz	zen of What C	Country?	
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36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Itams 23s or 28s-f ehow event, the Medical Exertinat rusal be multified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces  1 Yes 27  If Yes, Give Year or Dates:	?	1	If Yes, spe		Specify:	, Puerto Ri	ify Yes or No- ican, etc.)		Black, Wh		
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21215-0036	within and the state of the sta	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired	1)			377			
	filed v Hygie ather t		17. Father's Name (First, Middle, Last)				Unemp	толе		r's Name (	First, Middle,	NA Maiden			
lan	should be nd Mental marked o	To Be	Steven		Eď	wards			Gl	adys			Henso	n	
Maryland	s 1 and 2 should t Health and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relationship (7)		ster	200	reserve manufacture				Route Numbe				
Baltimore,	0 0		20a. Method of Disposition  Burial 2 Cremation 3   Donation 5 Other (Specify	Removal from State	20b. F	Place of Dispo cemetery, cre.	osition (Nai matory or c	me of other plac	e)	Da	te	20c. Lo	cation - City o	r Town, State	
altin	ertn orts inju		21. Signature of Funeral Service Licen:			Mt. Ca			ss of Facility	12 <b>–</b> 23	Balti		ndalk, Md	Md. 21202	
m	Depe Impo any ii		> Glady	Wan	حب		March	F.H	l. Eas	t	1101 E				
A	Physician /Medical Examiner parial-transit	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseq	quence of):	, , , , , , , , , , , , , , , , , , ,		NOTIC	CAN	טעויז טוכני	, u į n <sub>K</sub>	USERZ	= BYEA	
760	9 % 9	cail	(	d											
P.O. Box 68	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3[	⊒Ectopic p ⊒ Other (sµ					2	23d. Date of d Month	,	ear
	uires that signed by lid be deta	by	Part II. Other significant conditions co	SION		sulting in the u	inderlying o	cause giv	en in Part I.			bacco us		to the cause of de	
Vital Records,	The law requir ate has been si page 2 should I	Completed	TOBACCO.	ABUSE							24a. Was a autop perfor	sy med?	24b. Were autopsy findings available prior to completion of cause of death?		
ital	(Q	0	25. Was case referred to medical					_	26. Place	of Death (	1 □ Yes (Check only o	2 No ne)	1 L Ye	s 2 No	
of V	Physician: this certific ral director,	To B	TIM THE Z NO	Hospital: 1 X Inpati		ER/Outpatie			4 🗆 140		e 5 🗆 Resid			ecify)	
ion	Attending P	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Unity Work?  M 1 Yes 2 No					3d. Describe h	iow injury	y occurred				
Division	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of it	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28	Bf. Location (S City or Tow	street and n, State)	d Number or I	Rural Route Numb	er,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the besi iner: On the basis and manner s	of my kno of examina tated.	owledge, deat ation and/or in	h occurred ivestigation	at the tin	ne, date and pinion, deal	d place, ar th occurred	nd due to the o	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)	
	within To th compl	Me	29b. Signature and little of certifier				29	c. Licens	e number			29d. Date	e signed (Moi	nth, Day, Year)	
	20		Hato MA	Mo, m,	Lell			40	062	635	5 I	ECE	MBER	17,200	5
0	2		30. Name and address of person who of TTALO SUBBANA	completed cause of	death (Iter	m 23a) (Type,	Print) Wolf	EST	FREET	BA	14 mon	RE,	MD o	21287	
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2	32. Regist 0 2005 ▶	r <b>a</b> r's Signa	ature 5	128	E.				7		17, 200 21,287	

			For Stata Registrar	State of M	laryland / Depa <i>Cei</i>	artment of H		, ,	iene 19.005	41034
1 10			Decedent's Name (First, Middle, La	st)			-	2. Date of Death	h Day Year	3. Time of Death
	Physici /Medic		Bernice		Pai	rham			2005	7:30a <sup>M</sup>
	Examir		4a. Facility Name (If not institution, giv		)	4b. City, Town, or		ath	4c. County of Dea	th
Vege			University Hos			If Under 1 Year	timore	re la Data el Bieth	NA	
	Funeral		5. Social Security Number 6. S 220–05–8144	i⊡M 2XDF /.A	ge (In yrs. last birthday) 88 Yrs.	Months Days	Hours Mi	n. (Month, Day,	Year) C	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent					3-1-17		N.C.
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fs	ctor	Md.	NA	Balt	imore				1 Yes 2 □No
	or 28	Director	10e. Street and Number			10f. Zip Code	017	10	0g. Citizen of What C	ountry?
	ath w		1220 N. Woody				.217	/Oit- V1No	USA 14. Race - Am	odan Indian
	items items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces	?	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, Whi	
36	irs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2 😾 No	Specify:		Specify:	Black
215-0036	i 72 hours after death with the Maryland "natural", or items 23s or 28s-f show calcal Examinational be notified at		15. Decedent's E			dent's Usual Occup		orking.	16b. Kind of Business	/Industry
215	c * 3	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	d) mg most of w	ionaling .		
2	T 70 5	Con	11th grade 17. Father's Name (First, Middle, Last		Hous	sekeeping	40 Mark - d - N	In a Circa Adiabata A	Varies	
pu	d is b	Be	17. Father's Name (First, Middle, Last					ame (First, Middle, M		a la di sa
3	should be and Mental marked c	2	Oppie  19a, Informant's Name/Relationship (		nerrill	na Address (Street	·· <del></del> ·	Flora	City or Town, State,	abin Zin Code)
Maryland	That 7		Florence Parham	Daugh						
ē,	f Health item 27 other tr		20a. Method of Disposition	Daugi	20b. Place of Dispo	sition (Name of	(	Date 2	imore, Md 20c. Location - City or	Town, State
ПO	00= 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Mt. Cari	matory or other plac		-22-05	Dundalk,	МА
Baltimore,	교 는 판 등		21. Signature of Funeral Service Lice			2. Name and Addre			more, Md.	21202
ä	Depariment of the pariment of		& lady	o Wan	na -	March F.H	H. East		. North Av	
	H.		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not ent				est,	Approximate Interval Between
10	Physician		Immediate Cause (Final disease or condition	. Myoc	ARDIAL sa consequence of):	INFAR	2CTION	PROP	ABLE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):					
	Examine	_	Sequentially list conditions,	b. COR	s a consequence of):	ARTEK	A DIG	EASE		15 YEARS
	led sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D09 10 (01 a	s a consequence or,					
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit		(	d						
9	ificate g phys as the	edi						-		
Вох	leath certifica ettending ph I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy	v		23d. Date of de	
	s deat	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)	<u></u>		Month	Day Year
P.0	at the de d by the o	Physician/Medical	9 Unknown				on in Dock I	22a Did tob	maga usa santributa t	o the cause of death?
	ires tha signed I be det	ρ	Part II. Other significant conditions			This c			16	robably 4 Dunknown
o.	w require been sig should b	eted	HYPERZTE	70910 10	111-17	1172	- 7051	- I I UL	/	
Records,	e law has b	Completed						24a. Was ar autops perforn	v prior to	utopsy findings available completion of cause of
a				1				1 □ Yes 2	No 1 Ye	s 2 No
Vital	Physician: r this certific ral director, i	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	tient 2 ER/Outpatie	nt 3 DOA Oth	205	Beath (Check only on	e) ince 6 □Other (Spe	aciful
of	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of In	jury 28b. Time o	of 28c. Injur	ry at		w injury occurred	scriy)
<u>.o</u>	Attending Indeath.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	Day Year) Injury	M 1	Yes 2 □ No			
Division	er des	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of I	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or F	lural Route Number,
Ō	ospitei or Attandi hours after death unerel Director; A ly filled in by the fi	Cer			,,					
	To the Hospitei or Attence within 24 hours after death To the Funerel Director; completely filled in by the	edical	(Check only 2 Medical Exa	miner: On the basis	st of my knowledge, deat of examination and/or in	th occurred at the til evestigation, in my o	me, date and pla opinion, death o	ace, and due to the ca courred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	thin 2 the the implei	Med	one) 29b. Signature and title of certifier	and manner :	stated.	29c. Licens	se number	2:	9d. Date signed (Mon	th, Day, Year)
	F 3 F 8		> < 1.000 s	M A	121 1 0	7	16711	>	12/10	105
ı	d		30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	10 54	-1	12/10	1100
0	7			MSEL	1000 CA	THEORA	LST	BALTIN	DRE, MI	21201
	St	ate	31. Date filed (Month, Day, Year)		strar's Signature	( September 1)	•	- 1 - 1-1	-	
4.,	Regist	rar	DECO	2005	The state of the state of					

	Peter 05-084		nnings Parks <b>Pleas</b>	e Type or Print in					•		•	ole.						
	crn		For State Registrar	State of Maryla		artment of F tificate of			-	giene Reg. No	0.0	5	410	35				
	Physici		1. Decedent's Name (First, Middle, I	.ast)					2. Date of De. Month	Day	У	Year	3. Time of					
	/Medic	al		J. Parks					Decembe			005	9:49	A M				
1	Examin	er	4a. Facility Name (If not institution, g 202 River Way			4b. City, Town, o				40.	County o	of Death timo						
					s. last birthday)	If Under 1 Year			8. Date of Birt	th			DIE	or Foreign				
	Funeral Director		215-82-7604 1⊠M 2□F 41 Yrs. Months Days Hours Min.  Usual Residence of Decedent							y, Year)	964	Col	yland					
	Marylan	tor	MD Ba	ltimore 10c. C	City, Town or Lo	cation Owings M	fills						10d. Inside C	ity Limits 2√∑ No				
	or 28	Director	10e. Street and Number			10f. Zip Code				10g. Cit	tizen of W	hat Co	untry?					
	23a		202 River V			2111					U.S.							
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. V	Was Decedent of his Yes, specify Cub	lispanic Ori an, Mexican	gin? (Spec 1, Puerto R	cify Yes or No lican, etc.)	•	14. Race - American Indian, Black, White, etc.							
9600	nours aft urei, or	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No				105 1	Specify:		White					
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Rem 27 ie marked other than "nature!, or items 23s or 28s-1 show other traumatic event, the Majical Examinal must be notified at	Completed	mplete	mplete	mplete	mplete	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12		(Give	tent's Usual Occup kind of work done DO NOT use retire	during most	t of working	g	160. K	Gind of Bus		ruction	
Maryland 2	ould be filed Mental Hyg Larked other Latic event,	To Be C	17. Father's Name (First, Middle, La				18. Mothe		(First, Middle,		Sumame		0001011					
ary	2 should be and Mental ie marked eumatic ev		19a. Informant's Name/Relationship		19b. Mailin	ng Address (Street	and Numbe					State, Z	(ip Code)	93				
	Health a tem 27 is other tre		Lisa L. Parks	Wife		dden Cre	ek Co											
Baltimore,	t of He		20a. Method of Disposition 1- Burial 2 ☐ Cremation 3		Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Da	ate	20c. L	ocation - (	City or	Town, State					
Ë	tmen rtant:		4 Donation 5 Dother (Spe	city) St		es_Cemet							. Mary	Land_				
Bal	permit. Pages Department of I Important: If It ony injury or of		21. Signature of Funeral Service Lin	, engee		Name and Addre			.824 Re									
			23a. Part1. Enter the disease, or co	omplications that caused the der							vn, M	עוב	21136 Approximat	10				
	Dhysisian		shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line.					,		1		Interval Bet Onset and	ween Death				
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a conse		et Gun	JSMOT	WOV	NO GF	172	40			•				
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	be executed icien and burial-transit	xamlner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	a consequence of:							-						
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.O. Box	that the death certificate be ed by the attending physicie detached for use as the bur	ysiclan/M	Physician/Medical	ysiclan/M	ysician/M	ysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у				23d. Date Mon		,	Year
0_	The law requires that the ste has been signed by th bage 2 should be detache	by Ph	Part II. Other significant condition	s contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	obacco (	use contri	ibute to	the cause of	leath?				
rds,	quires nn sign uld be								101	res 2	<b>PS</b> No	3 🗆 Pro	obably 4 🔲	Jnknown				
Record	e law requir has been si je 2 should	Completed							24a. Was		24b. W	Vere au	topsy findings	available				
Ä		E O							perfo	rmed?	d	th?	2 □ No	ause or				
Vital	sicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					of Death	Chick only o	ne)								
of \	S S	မ	1 TYes 2 □ No		☐ ER/Outpatien	IL 3LI DOA							ofy) at so	cene				
	ing ine	lon:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ryat rk? ∣Yes 2.000		8d. Describe t	S- B	JE(	7 S.	HUT SKI	IK				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, building, etc. (Specify)  28b. Time of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28c. Place of Injury - At home, farm, street, factory, building, etc. (Specify)  ATHUM									8f. Location (5	Street ar	nd Numbe	or or Ru	ra i Route Num	ber.				
Θį	A Homicide determined determined determined determined building, etc. (Specify)								RIVER	way								
	29a. Certifier (Check only (Ch									stated	)							
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 X Medical Ex	caminer: On the basis of examination and manner stated.	nation and/or in	vestigation, in my o	pinion, dea	th occurred	d at the time,	date and	d place, a	ind due	to the cause(s	5)				
	To t com	ž	29b. Signature and title of pertifier	/		29c. Licens							n, Day, Year)					
	0		1 /	1		0	.C.M.	Ε.		Dece	ımber	17	, 2005					
1	0		30. Name and address of person w	no completed cause of death (Ite														
2	Sta	to.	31. Date filed (Mohit COa), Year	2005 32 Aedistrar's Sign	nature A	Pehn Str	eet,	Balti	more,	Mary	<i>r</i> land	21	201					
	Regist		HEA.Y.A.															

			For State Registrar	State of Maryl	and / De	partment of the artificate of	Health and M	Mental Hygid		41036					
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last  ELA   N  4a. Fecility Name (If not institution, give  BON SECONDS HON	street and number) (Ti)	TERSI TERSI WINE ST	4b. City, Town, o	or Location of Death	2. Date of Death Month ) } )	Day Year  4c. County of Dea	3. Time of Death S: 47 P M					
	Funeral Director		5. Social Security Number 6. Se		yrs, last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		thplace (State or Foreign puntry)					
36	the Maryland 28a-f show collified at	ector	Usual Residence of Decedent  10a. State 10b. County  MD n/a  10e. Street and Number		City, Town or			100	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Fracili ar must be natified at once.	by Funeral Director	2 Elinor Ln.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates:	in U.S. 13	2121  3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, White	erican Indian,					
21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 8th	ucation de completed) College (1-4or 5+)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire	during most of work	king	6b. Kind of Business	/Industry					
Maryland 2	should be filed and Mental Hygis marked other imartic event, II.	To Be Co	17. Father's Name (First, Middle, Last) Franf E. McAllis	ster	Pack	er		e (First, Middle, Ma							
	ages 1 and 2 sho nt of Health and I :: If item 27 is me r or other traums		19a. Informant's Name/Relationship (T) Robin Robey— Daugh 20a. Method of Disposition 1 Burial 2 Cramation 3 If	nter 20 Removal from State	12 b. Place of Dis	iling Address (Street 50 Poplar position (Name of emacre alterno ark	Ave. bal	timore, M	City or Town, State, .  D 21227  Oc. Location - City or  11timore (	Town, State					
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 □ Donation 5 □ Other (Specify 21. Signature Funeral Service License	7		22. Name and Addre	ess of Facility Lo	udon Park	Funeral	home					
100	Pnysician /Medical Examiner	27	23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cone cause on each line.  a Due to (or as a con	toni	His mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death					
8760,	te be executed ysician and e burial-transit	ical Examiner	cal	ical	cal	cal	cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a con c. Due to or as a con d.	sequence of):	mas culiti renal	Fac	lure		
P.O. Box 68	death certific e attending p od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death	B Ectopic pregnanc	у		23d. Date of de Month	livery Day Year					
	The law requires that the de ite has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause gir	very in Part I.	23e. Did tobal 1 □ Yes		o the cause of death?					
al Records,	: The law requir cate has been si : page 2 should	Completed	Mikal VI	24a. Was an autopsy performe 1 \sum Yes 2	topsy prior to completion of cause of death?										
ion of Vital	Attending Physician: The Ir death. c death. sctor: After this certificate ha	atlon: To Be	25. Was case referred to medical examiner?  1  Yes 2    27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	Hospital: 1 Ampatient 2 28a. Date of Injury (Month, Day Yea		of 28c. Inju	ner: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how	ce 6 Other (Spe	cify)					
Division	in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or Town,							
	To the Hospital within 24 hours of To the Funeral Symptetely filled	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam  29b. Signature and title of certifier	vician: To the best of my iner: On the basis of exame and manner stated.	knowledge, de nination and/or	ath occurred at the ti investigation, in my of	opinion, death occur	red at the time, date	se(s) and manner as e and place, and due I. Date signed (Mont	to the cause(s)					
1	h = = 8		30. Name and address of person who c	ompleted cause of death (	(Item 23a) (Typ	o. Print)	8327		17/16/	01					
1	Sta Registi		MOGES STEI 31. Date filed (Month, Day, Year) DEC 2 0	2005 Peristrar's Si	ignature	e, Print)  SGO LVC (	kens	Are	Selto	21229					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SOF MMORE Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Day, 6. Sex 1 M 2 □ F Social Security Number **Funeral** Days Months Hours Min. PENNSILVANIA 2793 Yrs. 219-76-2793 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State or Items 23a or 28a-f show the must be notified at MO 1 ☐ Yes 2 No AUREL TOWARD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number STEBBING USA 120 20723 Funeral Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 22 No Specify WHITE Baltimore, Maryland 21215-0036 Specify: the Medicul Ever þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1SABLED ISABLEN 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be TACKARO USEPH KICHMAN OROTHI 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number of Rural Route Number, City Town, State, Zip Code) 0. Box 488 MARKTON ISERRY SISTER 20b. Place of Disposition (Name of DECEMBER 200 Location - City or Town, State 20a. Method of Disposition cemetery, crematory 9 1 ■ Burial 2 Cremation 3 Removal from State permit, Page Department of Important: If any injury or once. MEMORIAL *tarkulle* WD MORELAND 17 7000 4 □ Donation 5,□ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CHAPEL 8800 (40) HARFORD MD 21254 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease of injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day ō 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ursing Home P 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; Director: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \[ \] Homicide within 24 hours a 1 V Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 0 2005

ORIGINAL

accorded

32. Registrar's Signature

GEORGE L. PFEIFER State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 4a per me G850 127207795aten Sf Death Reg. No. U 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** GEORGE L. PFEIFER 11:24 A<sup>M</sup> DEC. 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3813 RIDGECLOFT ROAD
RIGGECTOFT
5. Social Security Number
5. Sex BALTIMORE CITY BALTIMORE CITY 8. Date of Birth May 16, 1924 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **X**⊠M 2□ F SI Yrs. 219-18-1907 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County •how filed within 72 hours atter death with the Maryla Hygiene. other than "natural", or Iteme 23a or 28e-f ehov ent. Its wedical Exeminar must be codified a Baltimore City 1XX es 2 □ No Maryland Baltimore City Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 3813 Ridgecroft Rd. 12. Was Decedent Ever in U.S. Armed Forces?

X Yes 2 No 11
If Yes, Give WW 11
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XXNever Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Commercial Air Condition Mechanic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny lightly or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Pfeifer Anna Diepold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14413 Katie Rd. Phoenix, Md. 21131 19a. Informant's Name/Relationship (Type, Print) Patricia Moeler (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition X X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 12~20~2005 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup>Lassann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licenses MCKI 1725 VU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. ATTENSCLENDIC CONTINUASENTON disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physicien and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pl IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e sete hes been signed | pege 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 X No rector. 25. Was case referred to medical examiner? Be 26. Place of Death [Check only one] examiner: 1 X Yes 2 ☐ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 XOther (Specify) AT SCENE ဠ Ē 2 ER/Outpatient 3□ DOA After thir funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a

To the Funeral i

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16, 2005 U.C.M.E DEC. Jash 20 30. Name and address of person who completed cau at if death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 Tasha Z Greenberg M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 0 2005 Registrar

			4 101	eartment of Health and Mertificate of Death		ene 2005	41040
	Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Irene Elizabeth Porter			12, 2005	11:50 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Quail Run Assisted Living	4b. City, Town, or Location of Death Perry Hall		4c. County of Death  Baltimo	
	Funeral Director		5. Social Security Number 212-26-0354 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) Oct. 24,	(ear) 9. Birth Con 1928 May	nplace (State or Foreign untry) LYLAND
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits
	Mary -f sho	tor	Maryland Baltimore	Perry Hall			1 ☐ Yes 2 No
	or 28g	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	untry?
	ath wi		5124 New Gerst Lane	21128		u.s.A.	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a-f show ery injury or other treumatic event, the Modical Examilination at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
200-0	2 hou		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	3b. Kind of Business/l	ndustry
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7	led wi lygien her th			ral Designer		Florist	
/land	uld be fii Mental H Irked otl	To Be	17. Father's Name (First, Middle, Last)  Charles Gerst	18. Mother's Name Cecilia			
Mar	2 sho and I Is me			ling Address (Street and Number or Rura			
≥ ນົ	1 and Health 8m 27 ther t			6 Pepper Hill Road,		Oc. Location - City or 1	
2	ages nt of l t: If its			ematory or other place)		llerton, N	
Dallillor	permit. P Departme Importen eny injuri		21. Signature of Funeral Service Licensee	22. Name and Address of FacilitySchi	munek Fu	neral Home	es
	40200		23a. Part1. Enter the disease, or complications that caused the death. Do not en	9705 Belair Rd., Ba			Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		roopiiatory arres	.,	Interval Between Onset and Death
	/Medical		resulting in death)				
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> 5	Physic this ce al dire	မ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 Other (Spec	Assisted iv)Living
VISION	inding Fath. r: After re funera	atlon:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury	28c. Injury at Work?  M 1 Yes 2 No	8d. Describe how	injury occurred	
	al or Atte after de Directo d in by th	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal of medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
1	,/		Sovieder ( Miles MO	1) 27/88		12/14/05	
5			30 Name and address of person who completed cause of death (Item 23a) (Type	Print) Plan Den	NAC 1	11 7/2	27/
0	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature,	forded new men	Mayre R		
	Registr	ar	DEC O COOL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 005 Amend Item #2826 Per PHY C856 rtificate Of CB e 3th 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18 3. Time of Death Physician Month Year PAYTON WIL BERT 1:151 Dec 2005 /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** NIA 521 Harwood Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | C. C. 3, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land 1**X**M 2□ F 213-12-5346 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Baltimore other traumatic event, the Medical Examiner must be nutified at Catonsville 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nesley Avenue 21228 States United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No or Items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avon. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Tailor 17. Father's Name (First, Middle, Last) Charles Payton 18. Mother's Name (First, Middle, Maiden Sumame) Be Cora Spicer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Payton-Wife Catonsville, MD. 21228 127 Wesley Avenue Pervady Dec Date 24 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Golden Hill, MD. John Wesley U.M. Church 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign thre of Funeral Service Licensee 22 Name and Address of Facility I iams Funeral Service, P.A. P.D. Bex 11651 Baltimere, Maryland 21. Moun 2.1 Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIME'S primentia Priysician MUNTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician hed for use as the buria ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Physici 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Failure CUN 9 CSTING heur 1 Yes 2 No 3 Probably 4 Unknown Completed 1 rustage 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Daughter s Other: 4 Nursing Home 3 Aresidence 6 XX her (Specify) Residence Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this il Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 \ Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 052113 ~ 19 2015 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

301 St Sund

Son -~ nogo

32. Registrar's Signature

Paul

31. Date filed (Month, Day, Year)

21202

			1 - State Registrar	State of Maryla		artment of H		F	Reg. No.	5 41042
	- · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
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	Examin		4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of De	eath	4c. County of I	
			Sandtown N/H			Baltimo:	re		N/A	k.
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	Director		220-14-2420 A	M 20XF 104	Yrs.	Months Days	Hours M	lin. (Month, Day 5-2-1	901	S.C.
			Usual Residence of Decedent							
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	within 72 hours after death with the Maryland ene. Itan "natural", or iteme 23a'or 28a-f ehow Ita Madical Examinar must ba notiliad at	Funeral Director		2. Was Decedent Ever in	U.S. 13. 1			(Specify Yes or No-		American Indian,
	ter d	٦	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo	1	f Yes, specify Cuba	in, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	Black, \	White, etc.
36	rs af	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes XXNo	Specify:		Specify:	Black
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	0 40 5	11	19a. Informant's Name/Relationship (Type			-		Rural Route Numbe	r, City or Town, Sta Md 21209	
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ore	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location - Cit	y or Town, State
Ĕ	Page nent o int: If		4 Donation 5 Other (Specify)	Ki	ing Memo	rial Par	k - 12/	20/2005	Randallst	own, Md
Baltimore,	permit. Pages Department of the Importent: If Its eny Injury or of once.		21. Signature of Funeral Service Licensee	,	22	. Name and Addres	ss of Facility	March F	/H West	-
Ö	Depa Impo eny Ir	l III	Xale V	nanh			4300	Wabash A	venue Ba	1to, Md 21215
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o.	that the de led by the e detached f	hys	9 Unknown	9□ Unknown						
σ.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions conti	ributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
Vital Records,	uire Siga Id be							1 🗆 Y	es 2 No 3	Probably 4 Unknown
Ö	v rec	Completed						240 1450	245 1460	a automorphism and an automorphism
ž	has ge 2 :	dω						24a. Was a autop.	sy prior	e autopsy findings available to completion of cause of
=	: The	S							221No 1□	Yes 2□ No
ij	cien ertifi ector	Be	25. Was case referred to medical examiner?	-25-1				Death (Check only or	76)	
of	Physician: rthis certific ral director,	2	1 162 5740		☐ ER/Outpatien		4 Nursin	g Home 5 ☐ Resid	ence 6 Other	Specify)
	fler t	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	at k?	28d. Describe h	ow injury occurred	
<u></u>	Attending r death.	ati	2 Accident investigation			M 1 🗆	Yes 2 □ No			
	er de	ti i	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number o	or Rural Route Number,
ō	s afte	Certification:		building, sto. (Spec	~·· <b>y</b> /			ony or row	., oldio)	
	Hospitel 4 hours 54 hours Funerel tely filled		29a. Certifying Physi	cian: To the best of my kr	nowledge, death	occurred at the tim	ne, date and pla	ace, and due to the c	ause(s) and manne	or as stated.
	To the Hospitel or Attending Physicien: The inviting 4 hours after death.  To the Funerel Director: After this certificate had the Funerel Director: After this certificate had only the funeral director, page	edicai	(Check only a Medical Examine one)	or: On the basis of examinand manner stated.	nation and/or in	estigation, in my of	pinion, death o	ccurred at the time, c	late and place, and	due to the cause(s)
	Mithir Country	¥	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed (A	fonth, Day, Year)
			<b>)</b> / / / /		Warn.	- D	49-	1 (9	12/	19/05
	9		30 Na le and address of arrow who are	inleted cause of death	/ VY 74 (	Print)			10	7/298
4	7)		30. Nalle and address of erson who con	DIA	em 23a) ype.	F-11	1 6	olling 1	bel K.	11 4
			31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	nature (W)	7 10		11 11 12 1	1/	100 M
	Sta Registr		DEC 2 0 20		WA	mark 3		-		
			7 15 5 7 7 7 7 7 1 7 7 1 7 1 7 1 7 1 7 1	(C)	E Po	CONTRACTOR AND AND				

ORIGINAL

		State Registrar			Cei	rtificat	e of l	Death		Reg. Wo. U U	5	+1044
Physician	_	Decedent's Name (First, Middle	a, Last)						2. Date of De Month	Day	Year	3. Time of Death
/Medica	- 1	David Lee Qu							December	cr 10 2	205	(30bm
Examine	er	4a. Fecility Name (If not institution						Location of Dea	an of Death  Ac. County of Death  Ac. America  Black, White, e  Specify: Whi  Ac. County of Death  Ac. America  Black, White, e  Specify: Whi  Ac. County  B. Birthple  County  Ac. America  Black, White, e  Specify: Whi  Ac. County  B. Birthple  County  B. Baltimore  County  B. Baltimore  Cither's Name (First, Middle, Maiden Surmane)  County  Ac. County  Ac. County  Ac. County  Ac. County  B. County  Ac. County  B.	1.1		
	ε .	Baltimore Washingt		7. Age (In yrs.	last hirthday	If Under		If Under 24 Hr	B. Date of Bir			lace (State or Foreign
Funeral Director		218-36-9008 Usual Residence of Decedent	1 □XM 2 □ F	65	Yrs.		Days		. (Month, Da	av. Year)	Coun	inace (State of Poreign
A m		10a, State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
4 2	ğ	Maryland Anne	Arundal	Ra	1timor	0						1 ☐ Yes 2 🛣 No
1288	Director	10e. Street and Number	AT dilde1		ICIMOI	10f. Zip	Code			10g. Citizen of	What Coun	ntry?
38°	<u>a</u>	520 Taney Aven	ue			2	1225	,		USA		
E E	ner	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	I.S. 13.	Was Deced	ent of H	ispanic Origin? ( n. Mexican, Pue	Specify Yes or No	o- 14. Rac		
Enamin T	Completed by Funeral	1 ☐ Never Married 2 ★ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yas Giv	<sup>2</sup> □No <sup>'e</sup> <sup>ates:</sup> Viet		1□Yes		Specify:				
in in in	ted	15. Deceden				dent's Usua	al Occupa	ation	orking	16b. Kind of B	usiness/Ind	dustry
Man S	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT US	se retired	i)	nknig			
4	Sol	12			Fi	refig	hter			·		ity
0 0	Be	17. Father's Name (First, Middle,			C ==						· _	
T after	2	Arthui		uigley			10.					2.11
er traum		19a. Informant's Name/Relations Carolyn A. Qui		≘)							State, Zip	Code)
r oth	1	20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 DRomoval from	20b. I	Place of Disponentery, cres	sition (Nan	ne of ther plac	e)	Date	20c. Location -	City or To	wn, State
ury o		4 Donation 5 Other (S			stlawn	Memo	rial	Grds 12	/15/05 1	larriots	ville	. Marylan
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neture!", or them 23a or 28a-f ehow any injury or other traumetic event, the Medical Examination must be notified at any injury or other traumetic event, the Medical Examination must be notified at once.  To Be Completed by Funeral Director		21. Signature of Funeral Service	Licensee		_ 22	2. Name an	d Addres					
= # a			ming (t)			3620 T	Wilk	ens Ave.	, Baltin	more, MD	2122	29
4		23a. Part L Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	aused the dear ach line.	th. Do not ent	er the mod	e of dyin	g, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between
ician		Immediate Cause (Final disease or condition	_ a	<b>}~~</b> €	lignon	t me	rother	elioma				Onset and Death
dical niner		resulting in death)	Due to	or as a consec								
2		Sequentially list conditions,	b	or as a consec	nomes of							
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<									
al-tra	xar	that initiated events resulting in death) Last	c. Due to (	or as a consec	quence of):						-	
5 7	call		d									
attending physical for use as the back of												
endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregninth 2 Feta		Ectopic pr	ennancv				te of delive	,
ed fo	SICIE	in the past 12 months?		ant at time of o		Other (sp				Mo	nth	Day Year
igned by the a be detached to be detached to be detached to be be better the beautiful to be better to be the beautiful to be better to be the beautiful to be the bea	Ph.	9 Unknown	-						00 0111			
1 Ped 5	ò	Part II. Other significant condition					-	en in Part I.		,		e cause of death?
should t	ted		obs-huchve		\	عندفعتنا	ζ		1,0	Yes 2□No	3 Prob	ably 4 Dunknown
e 2 si	Completed by	0 ps tru	ctive slee	r apt L	4				24a. Was	DSV	prior to con	psy findings available npletion of cause of
page .	S								1 ☐ Yes		death? I 🗌 Yes	2 🗆 No
2 0 a	Be	25. Was case referred to medica examiner?	I Town to the second				Othe	0.00	ath Check only		_	
S D S	0	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of		<u></u>	4   Nursing	1	dence 6 Oth		")
or: After	Certification:	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	g (Moni gation	h, Day Year)	Injury	M	8c. Injun Work	Yes 2 □No	280. Describe	now injury occur	90	
in by th	rtific	3 Suicide 6 Could 4 Homicide determ	ined 288, Place	of Injury · At h ng, etc. (Speci	ome, farm, str fy)	eet, factory	, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Number,
y filled		29a. Certifier Check only	ig Physician: To the Examiner: On the b	best of my kno	owledge, deatl	h occurred	at the tin	ne, date and place	e, and due to the	cause(s) and ma	inner as st	ated.
	ō	one)	and mani	ner stated.	ation and/or in	vestigation,	. in my of	pinion, death occ	urred at the time,			
pletel	0	29b. Signature and title of certifie	1012	_				number		29d. Date signe		
completely fil	Me		WI AMM			I V	005	87119	4	December	(0 2	2605
complete	Me	) (law		_								THE PARTY OF THE P
complete	Me	30. Name and address of person		of death (Ite	m 23a) (Type,	Print)	0.	100	S. A. Annes.	210/1		
0	0	Albert Itan	Mp 30	1 1+05	epital 9	Print)	. Gla	en Burnu	e MD	21061		
within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral transfer.  Madical Cartification.	e	Albert Han 31. Date filed (Month, Day, Year)	MD 33	of death (Iter	epital 9	Drive		en Burnu	e MD	J1061		

	_ FUI	tment of Health and Mental Hygi ficate of Death	iege 005 41045
Physician /Medical	Decedent's Name (First, Middle, Last)     Randy L. Ridgley	2. Date of Death Month December	Day Year 11116 Qu
Examiner	St. Agnes Healthcare	b. City, Town, or Location of Death	4c. County of Death n/a
Funeral Director	217–58–1733 12 M 2□F 52 Yrs. N	If Under 1 Year If Under 24 Hrs. As Date of Birth (Month, Day, Dec 18,	Year) 9. Birthplace (State or Foreign Country) 1952 Maryland
ehow	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne Arundel  Jessup	ition	10d. Inside City Limits 1 ☐ Yes 2☑ No
with the Manual transfer of the Contract of th	10e. Street and Number 1601 Westbrooke Lane	10f. Zip Code 10	og. Citizen of What Country? United States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyghen in Traitment of Health and Mental Hyghen 1 haturel; or teme 23e or 28e-f show mit Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	is Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. In them 27 is marked other then "naturel", or my Injury or other traumatic event, the Medical Exam- Dince. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent (Give kin life. DO	nt's Usual Occupation and of work done during most of working NOT use retired)  urant Management	16b. Kind of Business/Industry  Retail Food
/land /	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, N Lucille Brake	Maiden Sumame)
, Mary and 2 shot saith and h n 27 is ma er trauma	19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> ) 19b. Mailing Mary F. Ridgley / Wife 1601 V		Maryland 20794
imore Pages 1 ment of He ent: # Hen	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5 Other (Specify)  20b. Place of Disposition cemetery, cremation  Bayview C	trematory 12/21/2005	20c. Location - City or Town, State  Baltimore, Maryland
Balt permit. Depart Import eny Inj pance.	In Rowe 410	07 Wilkens Avenue, Baltin	
Physician /Medical	23a. Pant 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	the mode of dying, such as cardiac or respiratory arre	Approximate Interval Between Onset and Death
1760, tie be executed ysicien and be burial-transit collinear transit collinear tran	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):		
Box 68 death certifica e attending ph ad for use as th		ctopic pregnancy Ither (specify)	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I. 23e. Did tob	pacco use contribute to the cause of death?
of Vital Records, P.O. Physician: The law requires that the rhis certificate has been signed by the rail director, page 2 should be detached: To Be Completed by Phys.:			y prior to completion of cause of death?  ANO 1 Yes 2 No
Pidglly   Randy  Division of Vital Reco  Division of Vital Reco  The Hospitel or Attending Physician: The law re hin 24 hours affect death the Funeral Director; Affect this centificate has be repletely filled in by the funeral director, page 2 sho  Redical Certification: To Be Complete	25. Was case referred to medical examiner?  1	28c. Injury at Work? M 1 Yes 2 No	ince 6 Other (Specify) w injury occurred reet and Number or Rural Route Number,
(a 3 kg	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death o (Check only 2 Medical Examiner: On the basis of examination and/or investigations)	occurred at the time, date and place, and due to the ca	suse(s) and manner as stated.
To the Hospi within 24 hour To the Funer completely fill	29b. Signature and title of certifier  Attpochase Physics Control (1998)	29c. License number 25	9d. Date signed (Month, Day, Year)
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	DS1853 1 Coston Avenue Ba	17 MARGE 21229
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Carlo	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#PII, perME, 0851, 1/26/06 TI

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day December **Physician** Main 16 50PM 17,2005 /Medical Lindow Legistration of Lindow 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Maryland Medical Center University Of 5. Social Security Number 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Country) New York If Under 1 7. Age (In yrs. last birthday) **Funeral** Months 84 166-16-1766 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event. The Modical Exercit art must be notified at 1 Yes 2 No Chestertown Director Maryland Kent 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 **USA** 240 River Road Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Nes 2 No 1941 If Yes, Give Year or Dates: Pages 1 and 2 should be filled within 72 hours after inent of Health and Mentai Hygiene. Int: if Item 27 ie marked other than "natural", or Itei 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify ð 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Nell Smith Stanley William Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary F. Robinson, Wife 240 River Road Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or ance. Metro Crematory Inc. 12/19/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor <sup>22</sup> Caremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Iraumatic Brain /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Fall death. investigation 05 12 16 within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Jown, State) At home, farm, street, factory, office 4 Homicide O River 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 17, 2005 17103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Balto, MD 21201 Strayer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear December 15 2005 8:21AM **Physician** UTKOWSKI 1 Ames /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital NIA 5. Social Security Number 6. Sex baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-20-297 Months 1 M 2 F MID July 20 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 Nes 2 No MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21214 U.S.A. AUC 6220 FAIR OAKS items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 ŏ WhiTE Specify: lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Şecondary (0-12) College (1-4or 5+) REFRIDSE 12+4 MechANIC CORP NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RUTKOWSKI ROSE GRASZ 흔 AUL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) 6220 PAIR OAKS AVE BILLS MS 21234 nt of Health : KUTKOWSKI GERTRUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12/19/05 Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of important: If any injury or once. SACRED HEART OF JESUS BAlte. MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility STella Fineral Home CHTD. HARTLEY MillER - STella Fineral Home CHTD. 7527 HARFELD LD. DAlto-No 21234 21. Signature of Funeral Service Licensee Stella 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterioscleratic Cardiovascular Disease fmmediate Cause (Final disease or condition resulting in death) **Physician** 4ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rointestina Bleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ★Yes 2 □ No certificate has b 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending

Division of Vital Records, death. within 24 hours after death To the Funeral Director: , completely filled in by the f

I a mes

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier Kartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

). Edlow, Douldle

D0002569

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

DONALD W. EDLOW Good Samar Itan Hospital, Baltimore, Maryland

31. Date filed (Month, Day, Year)

DEC 2 0 2005

32. Registrate Signature

DEC 2 0 2005

Registrar

Medical

State Registrar E. Southell.

DEC 2 0 2005

MD

32. Registrar's Signature

Hamelu

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar	State of Ma	aryland / i		rtment of H tificate of L		d Mental Hy	giene Reg. No.	05	41049	)
F	Physicia		Decedent's Name (First, Middle, La     BILL		UFFIN				2. Date of De Month <b>Decemb</b>	Day	Year	3. Time of Death	M
	/Medic Examin		4a. Facility Name (If not institution, giv		1		4b. City, Town, or	Location of De		4c. Cou	unty of Deatl	n 1847) 184	
-	1		Southern Maryla  5. Social Security Number 6. S		(In yrs. last bit	rthday)	Clinton  If Under 1 Year	If Under 24 H		th	ece Ge	orge  pplace (State or Fore	ign
	uneral rector		241-64-5172	<b>X</b> M 2□ F	63	Yrs.	Months Days	Hours M	in. (Month, Da	y, Year)		untry) Son N. C.	
and	À TI	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Loc	ation					10d. Inside City Lim	its
Mary	d ball	to	District of Colum	bia	Washi	ngto	n					1 ☐ Yes 2 ☐	No
ith the	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?	
aath w	0 23a	erai	2906 Pomeroy Roa	1 SE	Ever in II S	12 14	2002		(Specify Yes or No	Unite	d Stat		
d (17.12.12-000) filled within 72 hours after death with the Maryland Hygiene.	"natural", or iteme 23a or 286-f ehow colcal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 25 N  If Yes, Give Year or Dates:		lf.	Yes, specify Cuba	Specity:	erto Rican, etc.)		Black, White	e, etc.	
in 72 ho	if item 27 is marked other than "nature or other traumatic event, the Mudical E	Completed	15. Decedent's E (Specify only highest gr.	ide completed)		(Give k	ent's Usual Occupa kind of work done of O NOT use retired	luring most of v	working	16b. Kind o	of Business/I	industry	
d with giene.	## E	Com	Elementary/Secondary (0-12) Ninth	College (1-4or 5		aint	enance_E	nginner	•	Co	nstruc	tion	
tal Hy	event.	Be	17. Father's Name (First, Middle, Last	)					iame (First, Middle		пате)		
should no Men	marke	မ	Floyd Ruffin  19a. Informant's Name/Relationship	Type Print)	191	b Mailine	Address (Street a		se Bethea		wn State 7	in Code)	
and 2 s	27 ie r trau		Florence E. Ruff	** 1					Washingto			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Pages 1 a	Important: if item 27 is marked other then any injury or other traumatic event, <u>tra Ma</u> once.		20a. Method of Disposition  1 Disposition  1 Disposition  2 Cremation 3 Disposition  4 Donation 5 Disposition		cemete	ry, crem	ition (Name of atory or other place ion Cemet		ember 14		on-Cityor	Town, State	
permit. Departm	importa eny inju pnce.		21. Signature of Juneral Service Lice	<b>1</b> 500 /		22.	Name and Address	s of Facility R	obert G.	Mason	Funer	al Home	
വ ആദ്	F 2 9		Mund	·dy/					SE, Wast		n DC 2		
	sician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cau e on each lin	ERAL	not ente		JU OU		rrest,		Approximate Interval Between Onset and Death	K
	edical miner		f	Due to (or as:	a consequence	of):							
pet	ısıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		a consequence	of):							
execu	ohysician and the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence	of):							
ate be ex	physicis the bu	dicai	•	d									
A of the contribution	attending pl	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy					201	0-1		
The law requires that the death certificate be executed	signed by the atten id be detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			230.	Date of deli Month	Day Year	!
s that	gned b	by Pt	Part II. Other significant conditions	contributing to death be	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	
	been si								- 10	Yes 2 N	o 3∏Pro	obably 4 Unkno	wn
The law	2 0	Completed							24a. Was autoj perfo 1 Yes	osy ormed?	prior to death?	topsy findings availa completion of cause of	ble of
VIIC	certifi	o Be	25. Was case referred to medical examiner?	Hospital:	20.50		3□ DOA Othe	10	Death Check only		1011 10		
2 4	erald		1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatie 28a. Date of Injud (Month, Day		Time of	28c. Injury	at Nulsing	g Home 5 Resi			city)	
endin Sath	or: Aft	atio	f Natural 5 ☐ Pending 2 ☐ Accident investigation	n	/ rear)	Injury	M 1 0	Yes 2 □ No					
al or Att	il Direct	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		ury - At home, fac. (Specify)	arm, stre	et, factory, office		28f. Location ( City or To	Street and Ni wn, State)	umber or Ru	ral Route Number,	
• Hospit	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying P (Chack only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination ar	e, death nd/or inv	occurred at the timestigation, in my op	e, date and pla pinion, death or	ace, and due to the ccurred at the time,	cause(s) and date and pla	d manner as ce, and due	stated, to the cause(s)	
To th	To th comp	Me	29b. Signature and title of certifier				29c. License	-	45- 6	29d. Date si	-		25
7/	2	/	30 Nam and address of person who	completed cause of d	eath (Item 23a)	(Type, F	O UNE	(80)	82 U)4	KOGLO	F, Ale	6, 206 d. 206	02
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 0 201		ar's Signature	born	W				/		

			for State Registrar	State	of Maryland		artment o			nd Me	ental H	Hygie Reg.	2 U U	15	41050	
			1. Decedent's Name (First, Midd	le, Last)							2. Date of Month	Death	Day	Year	3. Time of Death	•
	Physici /Medic		Henry Bra	dford	Reckord					I		ber	18, 2		2:35P	М
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, To	wn, or Lo	ocation of	Death			4c. County	of Death		
			Edenwald				To	owson	n				Balt	imore	9	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 \		f Under 2 Hours	4 Hrs.	8. Date of	Birth Day, Ye	ear)	9. Birthp	lace (State or Fore	ign
	Director		219-01-3087	1 XM 2□ F	88	Yrs.					June				yland	
	pu		Usual Residence of Decedent  10a, State  10b, Count	,	10c City	, Town or Lo	cation							1	0d. Inside City Limi	its
	sho	5			100, 01,										1 ☐ Yes 2X N	
	he M	ecto	Maryland Balt	imore		T	owson					100	Citizen of	Man Cour		
	with t	늅					10f. Zip Co		- 1			Tog.			try ?	
	within 72 hours after death with the Maryland ene. than "netural", or items 23s or 28a-f show Its Modeal Executive Constituted at	<b>Funeral Director</b>	212 Bosley Av		cedent Ever in U.S	2 12	Man Danadan	2120		in? (Space	ifu Vac at	No	US 14 Bac	A Americ	an Indian	
	er de Item	5	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed F	Forces?	5. 13.	Was Deceden f Yes, specify	Cuban,	Mexican,	Puerto R	lican, etc.)	140-		ck, White,		
36	rs aft	by	3 X Widowed 4 □ Divorce	If Yes, G	2 □ No Bive Dates:		1 ☐ Yes 2 🏋	No :	Specify:				Specif	y: Whi	<b>t</b> o	
5-0036	tura stura	ed		nt's Education		16a. Dece	dent's Usual C	Occupatio	on	-		16t	. Kind of B			
215	in 72	Completed		st grade completed		(Give life.	kind of work of DO NOT use i	done dur retired)	ring most	of workin	g				•	
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	should be filed withir nd Mental Hygiene. marked other than imatic event, the M		17. Father's Name (First, Middle	, Last)							(First, Mio		den Suman			
an	ld be ental ked c	To Be	Henry	Reckor	d				Не	ester	•		Broo	ks		
Maryland	2 should and Men is marke sumatic	-	19a. Informant's Name/Relation			19b. Mailir	ng Address (S	treet and	d Number	r or Rural	Route Nu	mber, Ci	ity or Town,	State, Zip	Code)	
Ĕ	C1 60 W M		Bradford Recko	rd/Son		162	5 N.E.	941	th Av	veniie	Ba	tt1e	roun	d. WA	98604	
ē,	s 1 and 2 of Health itam 27 other tr		20a. Method of Disposition		00	ace of Dispo	sition (Name natory or othe	of		Da			. Location			
Baltimore,	00		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (		n State		ematory		11.5	2/20/	/ns	C	atons	vi 11e	, Maryla	nd
量	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	27 B	riet	22	Name and A	Address	of Facility	/						II G
Ba	permit. Departr Importa any inji		Bryan W. C	NUC	M	Le	emmon H	une	ral I	Home	of D	ulan	ey Va	11ey 2109	Inc.	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis		caused the death	. Do not ent	er the mode o	f dying,	such as c	cardiac or	respirator	y arrest,	للا وا	2103	Approximate	
	<b>.</b>		shock, or heart failure. Lis	t only one cause on	each life.										Interval Between Onset and Death	
70	Physician /Medical		disease or condition resulting in death)	a	16	mg	(A)	wit	ev						140	
Ţ	Examiner			Due to	o (or as a consequ	ience on:	1		1.	Eure					14-	
1		er	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a consequ	ence of	sun	1	w	une					1-1	
	ited	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<				0								
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consequ	ence of):								_		
8760,	ate be ex hysician the burial	a														
687	ficate physis the	Physician/Medical		0.												
Box	Jeath certifica attending ph for use as the	Ž	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnar								23d. Da	te of delive	ry	
ğ	atte	ciai	in the past 12 months? 1 □ Yes 2 □ No		birth 2 Fetal gnant at time of de		]Ectopic pregi ] Other <i>(speci</i>					_	Mo	onth	Day Year	
o.	the c y the ichec	iysi	9 Unknown	9□ Unk	nown							_				
٦,	res that the de signed by the a l be detached f	y P	Part II. Other significant condit	ions contributing to	death but not resu	Iting in the u	nderlying caus	se given	in Part I.		23e. D	id tobac	co use cont	tribute to th	e cause of death?	
sp	uires I sigr	d by									1	☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 hknov	٧n
Ō	w require been si should l	Completed		-							24a. W	÷ ∕asan	24b.	Were auto	nsv findings availab	ole.
Re	The lav	Ę.									a	utopsy erformed	17	death?	osy findings availab npletion of cause o	f
of Vital Records,			OF Mean and and to made								1 ☐ Ye		No	1 🗆 Yes	2□ No	
₹	Physician: this certific ral director,	Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital	71			Other:		sing Hom	(Check on					
of	Phys rahdi	5	1 Yes 2 No 27. Manner of Death			ER/Outpatier 28b. Time o		Injury at					6 □Oth		)	
on	ding P. h. After funera	to	1 Natural 5 ☐ Pend	ng (Mo igation	nth, Day Year)	Injury	м	Injury at Work? 1 ☐ Yes	s 2 □ N	lo			, ,			
S	Attending r death. sctor: After y the fune	lica	3 Suicide 6 Could	not be	ce of Injury - At ho	me, farm, str					Bf. Locatio	n (Stree	t and Numb	er or Rura	Route Number,	
Division	or A after Dira	Certification;	4 Homicide	mined 286. Plat	ding, etc. (Specify	,1						Town, S				
	spital		29a. Certifier Certify	ng Physician: To th	ne best of my know	wledge, deat	a occurred at 1	the time.	date and	d place, ar	nd due to t	the cause	e(s) and ma	anner as st	ated.	
	Hos 24 h Fur etely	edical		Examiner: On the												
	To the Hospital or Attending Physician: within 24 hours after death. To tha Funeral Diractor: After this certific completely illed in by the funeral director.	Me	29b. Signature and title of certifi				29c. L	icense n	umber			29d.	Date signe	d (Monthy)	Day, Year)	
	F > F ŏ			1/1 1	101			) 4	-9-	7 /-	9		12/	20/1	1	
	(1)	1	30. Name and address person	who completed car	use of death (Item	75(Cu	Print)	/	-	0	1	1 /	-+-	- ( 0	7 1770	
1	1	2	50. Name and address of person	A //	1010c Al	in (Type,	510	N	1/2	11.	1/2	1	14.1	16 1	2/228	
_	Sta	to	31. Date filed (Month, Day, Year	32.	Registrar's Signat	ure	3/0		1	un	)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	int	TO V		
	Registr		hen	0 0000		<i>n</i>	d 10			,						
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		•	For State Registrar	State of Maryland /		tment of		d Mental Hy	giene	005	41051
۶.	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	al	VERNON ROBIN			45 City Town	Location - 4 D	Decemb		ZUO	5 3.10 p. M.
	Examir	er	4a. Facility Name (If not institution, give s	treet and number)	(	BA 14	, or Location of D	eatn	4c. C	County of Deat	n
7	Funeral	- 12-	5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Yea	r If Under 24 I		rth	9. Birti	nplace (State or Foreign
40	Director		011 38 8447	M 2 F 52	Yrs.	Months Day	s Hours A	June 5	20,195	3	untry) M D
	and and		Usual Residence of Decedent  10a, State 10b, County	10c. City, To	own or Loca	ition			,		10d. Inside City Limits
	Mary IIst	tor	MD NI	a BA	Home	1 E					Yes 2□No
	or 288	irec	10e. Street and Number			10f. Zip Code	)		10g. Citiz	en of What Co	untry?
	23a	rail	1401 E. EAGER S.			2120				1.5. A	
396	be filed within 72 hours after death with the Maryland stal Hygiene. Indicate then "natural", or fleme 23a or 28a-f show event, its Medical Exart and met invite inciting a	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 Hoo If Yes, Give Year or Dates:	If Y		ıban, Mexican, Pı	? (Specify Yes or Nuerto Rican, etc.)		4. Race - Ame Black, White Specify:	
21215-0036	72 hou	ted	15. Decedent's Educ (Specify only highest grade		6a. Deceder	nt's Usual Occ	upation ne during most of	working	16b. Kin	d of Business/	
21	nithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use reti	red)	WOINING	0	.1 /	1
	e filed within al Hygiene. other then '		17. Father's Name (First, Middle, Last)	0	CEMEN	of Finis		Name (First, Middle	<del></del>	Struction	<i>'</i> 2
an	ld be ental ked o	o Be	Albert Bubinson				1	MIA FAUR		ŕ	
Maryland	s 1 and 2 should be f Health and Menta frem 27 le marked other traumatic ev	-	19a. Informant's Name/Relationship (Typ	pe, Print) 1	9b. Mailing	Address (Stre		Rural Route Numb			lip Code)
	and 2 saith a n 27 le		BERNICE ROBINSON			EAGE	n 37	BAILIMUNE			
Baltimore	t of He		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □Re	come	itery, crema	tion (Name of tory or other p		Date	1	ation - City or	
tim	t. Pag rtmen rtant:		4 ☐ Donation 5 ☐ Other (Specify)	TRINIT	4 CE	METERY	DEC	3 HS Fun	1	A Himix	E, MD
Bal	permit. Pages 1 Department of H Important: If Ite eny injury or ot 20028.		21. Signature of Funeral Service License	LA				St Bal			
1	,		23a. Part 1. Enter the disease, or complice	cations that caused the death. D						JAD 2	Approximate
100	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition		(	near	_			÷	Interval Between Onset and Death
40	/Medical		resulting in death)	Due to (or as a consequent	ce of):	V.C.					76 - 67 - 5
	Examiner		Sequentially list conditions, b	Due to for as a consaluence	20.061						
	nsit	nlner	cause. Enter Underlying Cause (Disease or injury	Due to for as a cons≖inen	ce ori:						
Ć,	be executed sicien and burial-transit	Exami	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):						
8760,	ate be ex hysician the buria	dicai	d								
9	death certificate be executed e attending physician and d for use as the burial-transit	0	IF FEMALE:								
Вох	eath certific attending p I for use as f	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. ff yes, outcome of pregnancy 1 Live birth 2 Fetaf dea	ath 3□E	ctopic pregnar			23	3d. Date of deli Month	very Day Year
0	6 <del>2</del> 2	ysic	1 Yes 2 No	4∏Pregnant at time of death 9☐ Unknown	n 5∐(	Other (specify)					
<u>a</u>	s that the	by Ph	Part If, Other significant conditions con	tributing to death but not resulting	g in the und	erlying cause	given in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ecords,	The law requires that ite has been signed b age 2 should be deta							_ 1_	Yes 2□	No 3₽Pro	obably 4 Unknown
ooa	e law requ has been je 2 shoul	Completed				31		24a. Was		24b. Were au	topsy findings available completion of cause of
$\alpha$		Com							ormed? 2 No	death?	2 🗆 No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:				Death (Check only			
of		-: To	1 Yes 2 No	1 □ Inpatient 2 □ EH/	Outpatient b. Time of	3□ DOA 28c. In	Other: 4 Nursin	g Home 5 Res		Other (Spec	oify)
on	ding f th. : After s tuner	ition	Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28t	Injury	W	lork? □Yes 2□No		,,		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, offic	Ç <del>0</del>		(Street and wn, State)	Number or Ru	ral Route Number,
	Hospital 14 hours a Funeral tely filled	edical (	29a. Certifier 1 Certifying Phys	ician: To the best of my knowled er: On the basis of examination	dge, death o	occurred at the	time, date and pl	lace, and due to the	cause(s) a	and manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medi	one)	and manner stated.			nse number	at the tall			
	Wil To		29b. Signature and title of certifier	mi		7 / C	いっとフィ	244	230. Date	signed (Monti	i, vay, redi)
7	2		30. Name and address of person who con	moleted cause of death (from 22	a) (Tune Pr	rint)	しった	<i>y</i> 11	12-1	13 103	
	0		Rachellewine Ban	mpleted cause of death (from 23. J Rm 235 JHB	mc "	9940	Easten	Avenue	= B	Hmn	e MD 21259
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Signature	de	۷,					
	Regist	air	nec 2 n 2005	Coluce 1 At	ALLEN	The same of the sa					

			For State Registrar	State of M	arylan		artment of F		d Mental Hy	giene Reg. No. 05	41052
			1. Decedent's Name (First, Middle, La	st)	-				2. Date of De Month		3. Time of Death
	Physici /Medic		Watter Fran	Klin		Ropk	a Jr.		12	16 05	7:40 AM
	Examin		4a. Facility Name (If not institution, giv			,	4b. City, Town, o		eath	4c. County of I	
			Mariner Healthcar				Catonsvi			Baltimo:	
	Funeral		5. Social Security Number 6. S	Sex 7.Ao MgM 2□F	ge (In yrs. I 76	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bin Vin. (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)
	Director		21, 21 10,2	A-X.'' 2	70	Y FS.			July 16	5, 1929 Ma	aryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	f sho	0	MD Baltimo	re							1 ☐ Yes 2X No
	the 1	Director	10e. Street and Number		_i		10f. Zip Code			10g. Citizen of Wha	it Country?
	3a or		2718 Yarnall Rd				21227			U.S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin	? (Specify Yes or No		American Indian,
9	after or Ite	Ē	1 Never Married 2 Married	1 XYes 2 If Yes, Give	No		1 Tes, specify Cuba 1 ☐ Yes 2 ②XNo		desto filoan, etc.)	Specify:	White, etc. White
215-0036	72 hours after death with the Maryland natural; or Items 23e or 28e-f show lical Examinat must be indilied at	d by	3 AWidowed 4 ☐ Divorced	Teal of Dates.	Y=59	528	100 20010	ороспу.			
5-0	72 h 'natu	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed)		(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of Busin	ess/Industry
12	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use retired Driver	2)		Steel	
121	iled v lygie ther t		17. Father's Name (First, Middle, Last	*)		Track	DIIVOI	18. Mother's	Name (First, Middle,		
auc	ntal hed of	Be	Walter Franklin R					Helen	( ,	Grimm	m
Maryland	should Me mark matic	70	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street		r Rural Route Numb		
Ma	ith ar 27 is r trau		Walda E. Boyd/Dau			4208	Spring Av	re. Hal	ethorpe M	21227	
ē,	s 1 and 2 sof Health are itam 27 is		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date	20c. Location - Cit	y or Town, State
e E	onto nt: If ry or	1	1 Burial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Speci				l Cemeter	y 12	-21-2005	Brooklyn,	MD
Baltimore,	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any njury or other traumatic avant. The Madical Examinating the multilad at once.	(	Sign, use of Funeral Service Lice	PA A	ss of Facility	II.m. of I					
ä	Depre Impor	/	Janu De	Court	neral i	Home of La rry Rd. La	ansdowne 1	4D 21227			
	_		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the death	h. Do not ent	er the mode of dyir	ng, such as car	diac or respiratory a	rrest,	Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition			relythm	ia				Onset and Death
1	/Medical		resulting in death)			uence of):					2000
	Examiner		Sequentially list conditions	b. Co10	ours.	Actes	disease				5,00
	모 등	Examiner	Sequentially list conditions, if any, loading to himsulationable cause. Enter Underlying Cause (Disease or injury								
	and -trans	Kam	that initiated events resulting in death) Last	c. Con a	din M	Uence of)					syears
8760,	be executed sician and burial-transit			11-116	oral 6	Vasunta	r disease				Sugars
687	ate hys	Physician/Medical		d	om -	200					- syears
ox 6	eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	ency				23d. Date o	f delivery
B	atter d for u	ciar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)	<u> </u>		Month	Day Year
0	that the de ed by the detached	hysi	9 Unknown	9□ Unknown							
۳.	res tha igned I be det		Part II. Other significant conditions	1 7	but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
rd	w require been sig should b	ed	Astr-March Ne	mentin					_ 1 🗆 1	Yes 2 No 3	Probably 4 Munknown
Records,	e law re has be je 2 sho	plet							24a. Was		re autopsy findings available r to completion of cause of
Ä		Completed by				21			perfo 1 ☐ Yes	rmed? dea	th? Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	2					Death (Check only	оле)	
of \	S S D	은	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpat		ER/Outpaties	. 0000		ng Home 5 Resi		Specify)
n o		Certification;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury	Wai	yat k? Yes 2 ∐ No	28d. Describe	how injury occurred	
sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not in	De See Place of Ir	nium, . At he	ome farm et	reet, factory, office	165 2 140	28f Location (	Street and Number of	or Rural Route Number,
Division	or A after Direction by	ertif	4 Homicide determined	building, e	etc. (Specif	y)	cot, factory, office		City or To		
	spital ours nerel filled		29a. Certifier 1 ☐ Certifying P	hysician: To the bes	t of my kno	wledge, deat	h occurred at the tir	me, date and p	place, and due to the	cause(s) and manne	er as stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner: On the basis and manner s	of examina						
	To th Within To th	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (A	Month, Day, Year)
	./		Bonne Cohener	1			10412	197		12/16/05	-
	6		20 Name and address of person who	completed cause of	death (Itén	n 23a) (Type,	Print)				
			Bonnie Cohen	7141 lecuri	5 B/L	Bul	house ,4	0 2.12	40		
		ate	31. Date filed (Month, Day, Year)	7141 Securi	trar's Signa	ature	books				
	Regist	rar	DEC 2 0	CUUD PRINCE	The Sand	200					

			For State Registrar	-	epartment of Health and N Certificate of Death	lental Hygien	211115 LIID3
	Physicia	an	1. Decedent's Name (First, Middle, Last)	1			3. Time of Death
	/Medic	al	VASHTI R. SMIT		4b. City, Town, or Location of Death	12.08.20	C. County of Death
1	Examin	er	BAYVIEW MEDICAL		BALTIMORE		NA
	Funeral		5. Social Security Number 6. Sex	144 OF 7 -	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	64 Y		01-31-1941	MD
	aryland how	_	10a. State 10b. County	10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Ma 28a-f	Director	MD BALTIMORI  10e. Street and Number	E WOODS	10f. Zip Code	10g. C	Citizen of What Country?
	3a or	Ī	2117 RAMONA LANE	4	21163		AZU
	r deatl	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland netural; or items 23e or 28e-f ehow dical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>⊠</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BLACK
9-0	72 hours "netural; adical Ex		15. Decedent's Edu (Specify only highest grade	cation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/Industry
121	within 7; ene. then "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER	,,,,,	DOMESTIC
d 2	Hygi Hygi ther		17. Father's Name (First, Middle, Last)	NA		e (First, Middle, Maide	
Baltimore, Maryland 21215-0036	ould be Mental arked o	To Be	CHARLES WILSON ,	SR.	ETHEL 1	ILGHMAN	
Many	and and		19a. Informant's Name/Relationship (Ty	(	Mailing Address (Street and Number or Run		
e, P	1 and 2 Heelth tem 27 other tra		MICHELE WILLIAMS  20a. Method of Disposition	(DAUGHTER) 211	Disposition (Name of		MD 21163 Location - City or Town, State
E O	000 ====		1  Burial 2  Cremation 3  P 4  Donation 5  Other (Specify)	lemoval from State WOODLA	v, crematory or other place) WN [2.17]	.05 BA1	ITIMORE MD
alti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens		22. Name and Address of Facility VAUGHN C. GREENE FUN		-
	20 E P 9		Vangha C	instings that arrived the death. Do a	5151 BALTO. NATE PIKE, E	SALTO, MD 21	229 Approximate
	<b>D</b>		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	Tilan	·	Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of	PV-VV-		
	Examiner	L		o			
V	ted nsit	nlner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	1).		
o,	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequence of	of):		
8760,	icate be physicie s the bu	Physician/Medical		d		· · · · · · · · · · · · · · · · · · ·	
9	leath certifica attending pt I for use as t	/Mec	IF FEMALE:	3c. If yes, outcome of pregnancy	11175		23d. Date of delivery
. Box	death e atten	Iclan	23b. Was decedent pregrant in the past 12 months? 1 Yes 2 ZNo	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O	that the de ed by the detached	Phys	9 Unknows	9 Unknown	4	22 a Did tahagar	o use contribute to the cause of death?
	8 E 8	þ	Part II. Other significant conditions con	nthouting to death but not resulting in	the underlying cause given in Part I.	1 ☐ Yes	10
Records,	w requir s been s should	Completed				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
l Re	The lav	mo				autopsy performed?	death?
Vital	Physician: 1 this certificel ral director, p	Be	25. Was case referred to medical examiner?	Jacoitali	104	th (Check only one)	
of	Phys rthis raldi	To	1 ☐ Yes 2 XNo  27. Manner of Veath	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou  28a. Date of Injury (Month, Day Year) In	tpatient 3 A Other: 4 Nursing H	ome 5 Residence 28d. Describe how in	
ion	Attending I r death. ector: After by the funer	ation	1 Actual 5 Pending 2 Accident investigation	(Month, Day Year)	njury Work? M 1 Pes 2 No	N	(A
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, str. et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	spital ours a ours a cours a c	Ce	29a. Certifier 1 Certifying hy	sician: To the best of any knowled e	, death occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	the Hospital hin 24 hours a the Funeral npletely filled	edical	(Check only 2 Medical Exami	ner: On the basis of examination in and manner stated.	d/or investigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
	To the complex	Σ	29b. Signature and title of gertifier	11	29c. License number	29d. 0	Date signed (Month, Day, Year)
	0		30. Name and address of person who co	ompleted cause of leath (item 222)	Type Print)	1 1	2/20/01
			Dr. Purcell B	aiter 4167	Postterson Av	e. Bal	to. mb 212-15
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Contes		
	Regist	rar	DEC 2 0 200	13 Ship show of			

		1 - For State Registrar	State o	of Maryland		rtment of H tificate of L		-	gieņe Reg. No.		41054
Physic /Med		1. Decedent's Name (First, Middle EDNA	SHE	ARER				2. Date of De Month 1)-ece mh	Day	970	3. Time of Death 5 00 PM
Exam	iner	4a. Facility Name (If not institution, Howard County (		imber)		4b. City, Town, or Columb		1	4c.	County of Dear	
Funera Directo		219-28-8253	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept	y, Year)	CC	thplace (State or Foreign buntry) aryland
f show	or	Usual Residence of Decedent  10a. State 10b. County	12		/, Town or Lo						10d. Inside City Limits 112 Yes 2 □ No
with the A a or 28a-	Directo	10e. Street and Number	ı/a -	Bo	altimo	10f. Zip Code	4000		-	zen of What Co	ountry?
Z I Z I 3-UU30  I within 72 hours after death with the Maryland jiene "naturel", or Items 23e or 28e-f show the Madical Examinar must be notified at	by Funerai	610 Brisbane Ro	12. Was Dec Armed F	2 XNo ive	11	Vas Decedent of Hi Yes, specify Cuba □ Yes 2√2 No	1229 spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	1	Jnited 1  14. Race - Ame Black, Whit  Specify: W	erican Indian,
within iene.	ompieted	15. Decedent (Specify only highes: Elementary/Secondary (0-12)			(Give life. [	ent's Usual Occupa kind of work done of OO NOT use retired, Homemaker	luring most of wor )	king	16b. Kir	nd of Business	
VIZING Z	To Be C	17. Father's Name (First, Middle, L William Armiger	,				18. Mother's Nam	ne (First, Middle,		,	
Mary and 2 shot alth and N 27 Is ma er treume		19a. Informant's Name/Relationsh Charles E. Shea		ısband		g Address (Street a					Zip Code) 21229
<b>DEALTIMOTE, IMALY JIANG A</b> permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other eny injury or other treumetic event, once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	State C6	ametery, crem dowrid	sition (Name of latory or other place ge Mem. P	ark 12/2		Elkr		Maryland
Depar Depar Impor		21. Fignature of Fonetal Service L	Link	<u> </u>	4		ns Avenu	e, Balti	imore		, Inc. land 21229
ate be executed / Medical / Medical Examiner physician and the burial-transit	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	occal  pence of):  No ma  pence of):	Meni. Gran			rrest,		Approximate Interval Between Onset and Death
The COLUAS, F.C. DOX 00/00,  The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐Live 4 ☐ Preg 9 ☐ Unkr		death 3 ath 5	Ectopic pregnancy Other (specify)				23d. Date of del Month	Day Year
law requires the as been signed 2 should be d	5	Part II. Other significant condition	ns contributing to d	leath but not resu	Ilting in the un	derlying cause give	n in Part I.				the cause of death?
The lar	Completed							24a. Was autop perio 1  Yes		24b. Were au prior to death?	topsy findings available completion of cause of
OI VITAL NEC Physicien: The lav this certificate has al director, page 2.	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2 □ 8	ER/Outpatient	3□ DOA Othe	26. Place of Dear	th (Check only o		□Other (Spec	Suffu)
Attending Phy ar death.  ector: After this by the funeral d	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investig.			28b. Time of Injury	28c. Injury Work		28d. Describe h			,
To the Hospitel or Attending Physiclen: Within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place	a of Injury - At hor ling, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and vn. State)	d Number or Ru	ral Route Number,
the Hospi nin 24 hou the Funer	edicai	(Check only 2 Medical E	Physician: To the examiner: On the band man	e best of my know pasis of examinati nner stated.	wledge, death ion and/or inv	estigation, in my op	inion, death occur	red at the time,	date and	place, and due	to the cause(s)
To with	×	29b. Signature and title of certifier	4 Of sum	٨		29c. License	30641		Decer	mber 1	5 200 5
10		30. Name and address of person v RAYNEH SHSAPMK	11 201-109	Back	River	Neck L	oad B	altomor	e 1	Verylore	121221
St Regis	ate trar	31. Date filed (Month, Day, Year) DEC 2 0	2005	gistrar's Signat	k A	and .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. UU 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Décember 10,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Baltimore HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 💢 F 213-70-1045 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Directo 1 XYes 2 □ No MARVLAND 10e. Street and Number 10g. Cirizen of What Country? Itams 23a EDERAL Completed by Funeral 2 should be filed within 72 hours after death and Mental Hyglene. Is marked other than "natural", or Itams 23. 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 28 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MGRADE OWN HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TOHN Jermit. Pages 1 and 2 show Department of Health - Important: If terminary in your or any injury or any or any injury or any or any or any or a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER) SPRIGGS ST. MD.21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State REMATORY 12-23-05 BALTIMORE 4 Donation 5 Other (Specify) 22. Name and Address: Facility BROW DEP N. FULTONA 21. Signaturite of Funeral Service Light see N. FULTONAVE, BALTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 500019 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events ding physician and resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cer this certificate 703 ZLI NO or Attending Physician: Diractor: After this certific 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Ulipatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Diractor: A investigation 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

State

29b. Signature and title of certifier

1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brook, MO 5601 LOCA

Baltimore, Raven

31. Date filed (Month, Day, Year)
DEC 2 0 2005

29a. Certifier

Medical

32 Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 16, 2005 **Physician** CARL W. STRAUB 9:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MARINER HEALTH AT NORTH ARUNDEL GLEN BURNIE 8. Date of Birth (Month, Day, Year) DEC. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 97 215-09-5878 1907 MARYLÁND **Director** Usuel Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 No GLEN BURNIE Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 101 PHELPS AVE. 21060 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married XYes 2 □ No Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: δ If Yes, Give Year or Dates: WW 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SHEET METAL WORKER CONSTRUCTION 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Peges 1 and 2 should be Depertment of Health and Mental Important: If Item 27 is marked o CHARLES STRAUB AMELIA MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL FRADY / GREAT NIECE 401 W. FURNACE BR. RD., GLEN BURNIE, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2005 LOUDON PARK CEM. 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral S vio Licenspe FUNERAL HOME, P.A. S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the ettending physicien and hed for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 2 No 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🗓 No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 XNatural 5 Pending М 1 ☐ Yes 2 ☐ No death. within 24 hours after death.
To the Funerel Director: A completely filled in by the fo investigation 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) \$ 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) D 50470 **DECEMBER 19, 2005** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRIDHAR ATLURI, M.D., 8109 RITCHIE HWY., PASADENA, MARYLAND 21122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 0 2005 Registrar

			1 - For State Registrar	State of Maryland		artment of H		_	giene 0 0 5	41057
9.	Physici /Medi	cal	Decedent's Name (First, Middle, La     Lisbeth Giletta S     4a. Facility Name (If not institution, giv	Stim		4b. City, Town, or	Location of Death	2. Date of De Month DECEMB	Day Yea	5 3:00 AM
	Examir Funeral	ier -	Saint Joseph  5. Social Security Number 6. S	Medical Cente ex 7. Age (In yrs. last		If Under 1 Year	TOWSO	77)	Bal	timore
	Director		220-05-1607  Usual Residence of Decedent  10a. State 10b. County	□ M 2 🛣 84	Yrs.		Hours Min.	January	b, year) 9. B 28,1921 C	XIOrd, MD.
	the Maryl. 28a-f sho	ector		ore County Carne		10f. Zip Code		***	10g. Citizen of What (	1 ☐ Yes 2 🛣 No
	3a or	Ϊ́	2719 Coldstream W	lay Apt.C			.234		United St	-
	death	hera	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		pecify Yes or No		nerican Indian,
900	be filed within 72 hours after death with the Maryland nat Hygiene.  Identify then "natural", or Items 23a or 28a-f show event, the Medical Examinat must be routiled at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Yes, specify Cubar	Specify:	Rican, etc.)	Black, Wh	white
15-(	"natu	letec	15. Decedent's En (Specify only highest gra	ducation 1 de completed)	6a. Deced	ent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of wor	king	16b. Kind of Busines	s/Industry
d 21215-0036	filed within Hygiene. other then "		Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last,		edica	l Assista	nt Super	visor	State of	Maryland
Maryland		To Be	Francis Faulkner				Giletta			
ary	A DEE	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street a	nd Number or Ru	rai Route Numbe	or, City or Town, State	, Zip Code)
	s 1 and 2 if Health a Itsm 27 is other tra		Mrs. Zonda S. Lar			Kings Ar	ms Drive	-	ton,Maryla	nd 21047
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	ceme	etery, crem S Fun		el Dec.			ill,Maryland
Ball	permit. Page Department i Important: II any injury or		21. Signature of Funeral Service Licer	J- Jan, Rr.	Pe 23	Name and Address aceful AI 25 York R	ternativ oad Tim	es Fune: onium,M	ral&Cremat aryland 2	ion Ctr.,P.A 1093
4 T			23a. Party. Extenthe disease, or com shock, or heart failure. List only	plications that caused the death. E one cause on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a METASTATIC		CANCER				Onset and Death
	Examiner			Due to (or as a consequent	ce of):					
7	* ".	ner	Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequent	ce of).					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	ate be exe nysician a ne burial-		resulting in death, cast	Due to (or as a consequent	ce of);					
687	, × e	dical		. d						
P.O. Box	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	signed signed d be de	by	Part II. Other significant conditions of END STAGE CHI	ontributing to death but not resultin						to the cause of death?  Probably 4 □Unknown
l Records,	The ete h	Completed	CACHEXIA					24a. Was a autop perfor	sy prior to med? death?	autopsy findings available completion of cause of
Vital	ysician: is certifice director, p	Be	25. Was case referred to medical examiner?	112-1			26. Place of Deat		The state of the s	
	Physic this c	٦	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/			4 U Nursing Ho		ence 6 □Other (Sp	ecify)
Division of	ding After funer	Certification:	27. Mathrer of Death  1 X Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not b.	(Month, Day Year)	b. Time of Injury		es 2 No		ow injury occurred	
Ρ	Ital or A irs after ral Directed in by	Certif	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Tow		
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 M Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the d red at the time, o	ause(s) and manner a late and place, and du	s stated, e to the cause(s)
)	To the within 2 To ths complet	Σ	29b. Signature and title of certifier	and a		29c. License		2	29d. Date signed (Mon	ith, Day, Year)
	5		30. Name and address of person who	completed cause of death (Item 23	а) (Туре, Р			r		
			BOON FOH LIM	4. D. 7601 OSI	ER.	DRIVE, T	гоизои,	MARYLI	AND 21204	ŀ
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		· very				
DH	MH 17 Rev 1/20		DEC 2 0 2005	forms & A	OBAR.	9				

ORIGINAL

		1 - For State Registrar	State of M	arylan		artment tificate			nd Mental I	lygiene Reg. Ne	1005	41058	)
Physic /Med		1. Decedent's Name (First, Middle Victory J. Sch	afer						2. Date of Month	uiber Da	15 200		и
Exam	iner	4e. Fecility Name (If not institution) 2016 Kalmia Ro	ad				1 Air	cation of C Under 24		На	arford		
Funera Directo		5. Social Security Number 197–34–6626  Usuel Residence of Decedent		62	ast birthday) Yrs.				Min. (Month	Day, Year)	C	thplace (State or Foreig cuntry) ennsylvania	
Marylanca-f show	ctor	Md. Harf	ord	10c. City	, Town or Lo		Air					10d. Inside City Limit: 1 ☐ Yes 24 ☐ No	
ath with the 23s or 28	ral Director	10e. Street and Number 2016 Kalmia Ro				10f. Zip (	210			υ.	izen of What Co		
DESIGNOTE, INISTY STATE A LABOURS  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exertinal must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' at Yes 2 If Yes, Give Year or Dates:	?		Was Decede f Yes, specif 1 ☐ Yes 2		anic Origin Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: W	e, etc.	
d within 72 ho giene. or then "natur.	Completed	15. Decedent (Specify only highes  Elementary/Secondary (0-12)		5+)	(Give life. L	tent's Usual kind of work DO NOT use	k done duri e retired)	on ing most of	f working		S. Gove		
yland a louid be filed I Mental Hygi harked other hatic event, I	To Be Co	17. Father's Name (First, Middle, I	ast)		marrag	gement			Name (First, Mid y Penzel	dle, Maiden		- I IIIICH C	
e, Mar, 1 and 2 sho Health and I em 27 Is me		19a. Informant's Name/Relationsh  Gerald L. Scha  20a. Method of Disposition		20b. Pl	2016	Kalmi	a Roa		el Air,	Md. 2			
Galtimor  Dermit. Pages Department of mportent: If it it it in light or one	ů,	1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sc. 21. Signature of Funeral Service I	ecify)	CE	view C	ratory or oth Cremat	ory	i	2/16/200	5 Bal	ltimore	Md.	_
Dermi Depa Impo	all de la company de la compan	23a. Part1. Enter the disease, or shock, or heart failure. List	Culler complications that cause	d the death	6	10 W.	MacI	Phail	al Home Road, B	el Air	Air, .	21014 Approximate Interval Between	
Physiciar /Medica Examine	1	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	Non	ence of):	ll Ce	111 L	uus	Cancer			Onset and Death    Simulate 1	
	Ical Examiner	Sequentially list conditions, if any, leading to immediate the second cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as										_
The COLOGS, P.O. DOX 00/00,  The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pre			_		23d. Date of del Month	ivery Day Year	
w requires that been signed be deta	þ	Part II. Other significant conditio	ns contributing to death t	out not resu	Ilting in the ur	nderlying car	use given i	in Part I.				the cause of death?	1
	Completed								pe	tas an utopsy erformed?	prior to death?	ntopsy findings available completion of cause of	В
g Phy g Phy er this	lon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending			ER/Outpatien 28b. Time of Injury		Other: c. Injury at Work?	4 🗌 Nursin	Death (Check on ng Home 5 28 28d. Descri	esidence		cify)	
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place of In	jury - At ho tc. <i>(Specif</i> y	me, farm, stre			2 140	28f. Locatio	n (Street an Town, State	nd Number or Ru n)	ural Route Number,	
the Hospi hin 24 hour the Funer npletely fill	Medical	(Check only 2 Medical I	Physician: To the best exeminer: On the basis of and manner si	of examinat	wledge, death ion and/or inv	estigation, i	in my opini	ion, death o	place, and due to to occurred at the tin	ne, date and	d place, and due	to the cause(s)	
\$ 1 × 1 × 2		29b. Signature and title of certifler	funs	<u> </u>	(12a) (T	Point		4439		Dec	embe	1.5. 2003	
6	itate	30. Name and address of person of the cent A. Ginn 31. Date filed (Month, Day, Year)	incrotto 4	BN rar's Signal	th Av	A 310	Be	1 Aci.	الله الله	14			
Regis		DFC 2	0 2005	ance o	18 6	parke							

Amend item#29d, permer, Brint in Black Indelible Ink. Ensure All Copies Are Legible. George Stakias 05-8534 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AKG Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 17, 2005 **Physician** Stakias George Peter 3:37 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 18, 1973 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 32 217-80-6137 Yrs. Maryland **Director** Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harkord Joppa Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Itame 23a or Examiner must be 1712 Heim Lane 21085 U.S.A. Pages 1 and 2 should be filed within 72 hours after death trment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Painter Painting Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pete Georgios Stakias Genevieve Leotsakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 Id Mrs. Juliette Stakias (wife) 1712 Heim Lane, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department in Important: If eny Injury or once. 12/22/2005 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPUS DUSURIUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Causto for as a considuence of Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Day

Be Completed by Physician/Medical page 2 Certification: Director: within 24 hours at To the Funeral Di completely tilled in

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year)

resulting in death) Last	Due to (or as a consequence of):
	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregna  4 Pregnant at time of death 5 Other (specify,
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause
25. Was case referred to medical	
examiner? 1XXYes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☑ FR/Outpatient 3 ☐ DOA
27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. Time of 28c. In (Month, Day Year) Injury 0
2 Accident investigation	on 12-17-08 143221M

23e. Did tobacco use contribute to the cause of death?

2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an autopsy performed?

	1 Yes	2 □ No		/es	2 🗆 No
ath (C	heck only	one)			
Home	5 🗌 Resi	dence	6 □Other (S	Specif	y)

26. Place of De Other: 4 Nursing I 28d. Describe how injury occurred Injury at Work? 1 Yes 2 No

MOTORCYCLIST STRUCK GUARD RALL Location (Street and Number or Rural Route Number, City or Town, State)

NO MARILYN AVE ESSEXMY

FOD DWFM	SBMULOL	MOI WHITAM 170
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to the caus	e(s) and manner as stated
2 Stortical Examines: On the basis of examination and/or investigation in accordance		

given in Part I.

one)	Z Medical Examine	and manner stated.	tigation, in my opinion, death occurred at the til	ne, date an
Signature and	title of certifier	. 1	29c. License number	29d. Da

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Howwe The Yhill

0

6 Could not be

O.C.M.E.

ate signed (Month, Day, Year) December <del>17</del>, 2005

d place, and due to the cause(s)

address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland MARGINAN KOREL

21201

State Registrar

Medical

			-	/ Department of Health	-	
			1- State Registrar	Certificate of Deat	i de	Reg. No.005 LIDED
			Decedent's Name (First, Middle, Last)	- John Odlo O. Dodl	2. Date of Dea	
	Physici		Cecelia Anna Schirmer		Dec.	18, 2005 1920 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		4c. County of Death
			Bayview Medical Center	Baltim		n/a
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Year If Und Months Days Hour	ler 24 Hrs. 8. Date of Birt s Min. (Month, Da	h 9. Birthplace (State or Foreign Country)
	Director		217-22-2816 1 M 2 M F 79 Usual Residence of Decedent	113.	2/17	/26   Maryland
	yland yland			Town or Location		10d. Inside City Limits
	a-f st	ctor	Md Baltimore N	1iddle River		1 ☐ Yes 2 🔼 No
	ith the	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	ath w		239 Orville Road	21221		USA
	itam itam	Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 ★Never Married 2 Married  1 ★Never Married 2 Married	13. Was Decedent of Hispanic 6     If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	hours after death with the Maryland tural; or Itame 23a or 28a-f show at Evantiner must be notified at	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 X No Speci	ify:	Specify: White
21215-0036	n 72 hours after death with the Marylan "natural", or itame 23a or 28a-f show salcal Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	nost of working	16b. Kind of Business/Industry
2	ithin 76.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during m life. DO NOT use retired)	iost of working	D 1
	be filed within 72 ho ital Hygiene. od other than "natu: event, tra Medical		8 0	Decorator	About No. of Control Address	Bakery
anc	ould be fi Mental P arked ot atic ever	Be c			<sub>ither's Name (First, Middle,</sub> nna Marie V	
Maryland	should be ind Menta i marked umatic ev	으	Anthony Frank Schirmer, S	19b. Mailing Address (Street and Num		
	0.00 = 0		Verda Mae Schirmer			iver, Md. 21221
ē,	os 1 and 3 of Health filem 27 rother tr		20a. Method of Disposition 20b. Pla	ice of Disposition (Name of metery, crematory or other place)	Date	20c. Location - City or Town, State
Ē			I Bullat 2 KClettiation 3 Inemoval Butti State	vview Crematory	12/19/05	Baltimore, Md.
Baltimore,	permit. Pag Department Important: I any injury o onca.		21. Signature of Funeral Service Dicensee			ome P.A. timore, Md. 21222
•••	207		Eugene ( autro p			
			23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. Lisyonty one cause on each line.	Do not enter the mode of dying, such	as cardiac or respiratory ar	rest, Approximate Interval Between Onset and Death
ų l	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Renal Fai			5.05( 2.13 2.54.1)
	Examiner		Due to (or as a conseque			
83	# · ·	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Renal Disease		
	cuted nd ransit	Examiner	that illitated events			
Ď,	be executed sician and burial-transit		resulting in death) Last Due to (or as a conseque	ence of):		
8/60	6 × 6	dical	d			
20 X	The law requires that the death certificat ite has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnan	CV		201 Date of the c
ROX	atten I for u	clan	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 4 Pregnant at time of deal of the past 12 months?	leath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	that the de ned by the a detached f	hysi	9 Unknown 9 Unknown			
ນັ	gned l	by P	Part II. Other significant conditions contributing to death but not resul			bacco use contribute to the cause of death?
ğ	w requires to been signer should be	ted	Ischaemic cardiomyopathy, N	lyocardial Inta	rction 10Y	es 2. ☑ No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	as be	Completed	Paroxysmel atrial fibrillat	ion, Hypertens	ion 24a. Was a autop	
		Con	Dementia, Stroke		perfor	méed? death? 2,8≦No 1 ☐ Yes 2.12≦No
<u> </u>	Physicien: The fav this certificete has ral director, page 2	Be	25. Was case referred to medical examiner?	Other	ace of Death (Check only or	
ō	£ ≅ ≅	- To	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TO dipatient 3 DOA 4	Nursing Home 5 Resid	ence 6 Other (Specify) ow injury occurred
0	Attending ir death. ector: After by the fune	tlor	27. Manner of Death  1. ★Natural 5 □ Pending  2 □ Accident investigation	28b. Time of Injury Mork?  M 28c. Injury at Work?  1 ☐ Yes 2		,,
DIVISION	Atter ar dea ector by the	iffica	STICOURS OF THE STICOURS OF TH	ne, farm, street, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number,
5	tal or	Certification:	building, etc. (Specify)		City of You	n, Siate)
	Hospi 4 hou Funer ely fill		29a. Certifier  (Check only  2 Medical Examiner: On the basis of examination	ledge, death occurred at the time, date on and/or investigation, in my opinion, d	and place, and due to the d	cause(s) and manner as stated.
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License numbe		29d. Date signed (Month, Dey, Year)
	8 4 8	_	Ami u Man Wa			
	0		30. Name and address of person who completed cause of death (Item 2			December 18, 2005
	2			venue Baltimor	e, Maryland	d 21224
	Sta	196	04 D-1-17-4 (14-4) 0-1 (1-1			
	Registr	ar	DEC 2 0 2005			

			rieas	e Type of Pill							egible.	
			1 _ For State	State of Ma	-	-			Mental Hy	giene	000	11001
			Ragistrar			ertifica	ate of D	eath		Reg. No.	005	41001
	Physici	an	Decedent's Name (First, Middle,						2. Date of De. Month		Year	3. Time of Death
	/Medi		Walter A. Syl						Dec.	18°,		5:15 a™
	Examir	ner	4a. Facility Name (If not institution, g	give street and number)		4b. Cit	-	Location of Death		4c. 0	County of Death	1
_			Stella Maris	Cay 7 Age	(In um lant hirth	fauc) If I loc	I 1 MC	nium If Under 24 Hrs.	9 Date of Rid	В	altimo	
	Funeral Director		5. Social Security Number 6 2 1 3 - 0 7 - 7 5 1 9	. Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last birtho 90 Yr	Month		Hours Min.	8. Date of Bird (Month, Da 4 / I 4	713	COL	pplace (State or Foreign intry) Yland
			Usual Residence of Decedent		70				7/17	, 1 )	1101	yrand
	yland Mow		10a. State 10b. County		10c. City, Town o	or Location						10d. Inside City Limits
	Mar.	ţ	Md r	n/a		Ва	ltimo	re				1 XYes 2 □ No
	h the	Director	10e. Street and Number				Zip Code			10g. Citiz	en of What Cou	untry?
	th wit	a	2108 Boston St	reet Apt	. 401		21	231		U	SA	
	be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland of other than "naturel" or items 23a or 28a-f ehow event, I'm Medical Examination man be notified at	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Dec	cedent of His	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Amer Black, White	
98	or it	Y.F.	1 Never Married 2 Married	If Yes, Give	lo		2 <b>7</b> No	Specify:		1	Specify	
Ö	hours	p	3-€ Widowed 4 Divorced	Year or Dates:							WI	nite
ιċ	n 72 'nat	iete	15. Decedent's (Specify only highest	grade completed)	(0	Give kind of t	sual Occupat work done du Luse retired)	iring most of work	ung	165, Kin	d of Business/li	ndustry
5	withii then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Cle				Bet	h Stee	e1
5	filled Hygi other	Ö	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	e (First, Middle,	Maiden S	Surname)	
מ	d be ental ked c ev	To Be	Antoni Szczył	oor				Stofar	nia Kom	ros		
A $. \mathit{M}.$ Marviand 21215-0036	should ind Men marke	-	19a. Informant's Name/Relationship		19b. N	Mailing Addre	ess (Street ar	nd Number or Rui	The second secon	-	Town, State, Zi	ip Code)
	C = 64 F		Mrs. Elaine Pe	arce	118	39 H	arfor	d Rd. (	Glen Ai	cm,	Md. 2	21057
5:15 Baltimore	S 1 e f Hez litem othe		20a. Method of Disposition		20b. Place of D	isposition (A	vame of	,	Date	20c. Loc	ation - City or T	own, State
5:1: mor	Pages Hent of Int: If it		1 ☐ Burial 2 🗖 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe					y 12/2	1/05	Balt	imore	. Md.
=	permit. Departm Importa		21. Signature of Funeral Service Lig					k i Faciliane				, 1141
ä	permi Depa impo eny ii		Eugens.	Cath				alk Ave				. 21222
	里 搬 油		23a. Part1. Enter the disease, or construction of the shock, or heart failure. Life or	mplications that caused								Approximate Interval Between
	Physician		Immediate Cause (Final	illy office cause of f cause in	NONE	065	1029	FINE A	ing		1515	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of)							
	Examiner		20.50.00.00.00.00.00									
,		Je.	if any, leading to immediate	Due to for as	a consequence of)		-					
V	te be executed ysicien and te burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.								
Ċ	e exe ien al irial-t	E	resulting in death) Last	Due to (or as	a consequence of)							
75 1760	ate be nysici	Ical		d.							_	
2002 <b>x 68</b>	certificat inding phy use as the	Med	IF FEMALE:									
3, 2 Box		Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2  Fetal death	3 Ectopic	pregnancy			23	3d. Date of deliving Month	very Day Year
87	ne dea the at	sici	1 Yes 2 No	4 Pregnant at 9 Unknown	time of death	5 Other	(specify)				MOUTH	Day real
	a y	Phy						in Brown	an Did to			
DECEMBER	ires tha signed d be del	þ	Part II. Other significant condition	SACAC S	at not rasmining in ti	ie underlylni	g cause giver	nın Pan I.		res 2□		the cause of death?
DECEMBI Records	w require been si should b	ted	- Chickey	15 5-06 55	d/286	C.5				res 2	INO SEPTO	bably 4 Unknown
DE CE	aw aw aw 2 si	pldu		7.07.7					24a. Was autop	sv	24b. Were aut prior to co	opsy findings available ompletion of cause of
-	The cate his page	S	1805/2/2	01800	CDIE				perto 1 ☐ Yes	rmed?	death? 1 ☐ Yes	2 No
SYBOR of Vital	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?					26. Place of Deat	h  Check only o	ne)		
SYE	hysi this o	P	1 Yes 2 Vo		nt 2 ER/Outp			4 Diersing Ho	ome 5 🗆 Resid			ify)
-	ing F	0	27. Manner of Death 1 Satural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Tin (Year) Inju	ıry	28c. Injury Work		28d. Describe h	now injury	occurred	
WALTER	Attending r death. ector: After oy the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no	the -		M		es 2□No	006 t anation (6		Management	
WALTER	i or Al after d Direc	E	4 Homicide determin		ury - At home, farm c. <i>(Specify)</i>	i, street, fact	ory, office		City or Tox	vn, State)	Number or Hui	ral Route Number,
Z _	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier Sertifying	Obversion To the base	of many land	footh	and 04.45	data == d =1==	and direct the	00112-7-1		
	Hos 24 ho Fun fely f	lica	(Check only 2 Medical En	Physician: To the best of	examination and/o	or investigati	ed at the time ion, in my opi	e, date and place, inion, death occur	red at the time,	cause(s) a date and p	ind manner as : place, and due :	stated. to the cause(s)
	thin 2 the or the	Medicai	29b. Signature and title of	and manner sta			29c. License	number		29d. Date	signed (Month)	Day Year)
	To To cor		103	ded	12.50		7	1500			- 19	
	/	1	20.41									
	15		30. Name and address of person when EDDIE NAKHUDA, it		eath (Item 23a) (Ty $JLANEY \;\; VA$		DO N D	TTMONTTIN	ו מוא א	002		
- 1	200	ate	31. Date filed (Month, Day, Year)		ar's Signature	. 1006	NOAD	TIMONIUM	1, MD 21	.093	1537	
	Regist		DEC 2 0		L	1.00						

			1 - For State Registrar	State of Maryla		artment of F		d Mental Hy	ygiene Reg: No.	5 4	1062
45	Physici	an	1. Decedent's Name (First, Middle, Last	)				2. Date of D	eath Day	Year	3. Time of Death
	/Media		Clara B. Slag						ber 13,	2005	2:10 A M
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o		eath	4c. Count	y of Death	
	<u> </u>		Gilcrest Hospice 5. Social Security Number 6. Se	x 7 Age (In vo	s. last birthday)	If Under 1 Year	OWSON  If Under 24 F	Irs. 8. Date of B	irth		timore
274	Funeral Director			DM 2KDF 70	Yrs.	Months Days	Hours M	oct. 1	9, Year) 1935	Coun	place (State or Foreign htry) Cyland
1772	PC _		Usual Residence of Decedent			1					
	anyla how	-	10a. State 10b. County		City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2X No
	the M	ecto	MD Balti	more		Baltin	nore		40-00	115 1 2	
	with with	Funeral Director	310 Wisewell Cour	t		10f. Zip Code	21227		10g. Citizen of	ted St	·
	death ma 23	ега	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		(Specify Yes or Nerto Rican, etc.)		ce - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Itema 23a or 28a-f show any injury or other traumatic event, It is Medical Examination to incitified at once.	by	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 ZÑNo If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 No		erto Rican, etc.)	Speci.	ick, White, of	white
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		dent's Usual Occup		vorkina	16b. Kind of E		•
2	within ene. then "	ld m	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use retire	d)	<b>3</b>	Glass		Le
2	e filed within at Hygiene. I other then '		12 17. Father's Name (First, Middle, Last)		F.	actory Wo		lame (First, Middle	Factor		
and	d be f antal l	o Be	George A. Mason,	Sr.				Mav Rize		110/	
Ž	should ind Men marke	은	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street		Rural Route Numi		. State, Zip	Code)
ž	and 2 ealth a n 27 is		Carl E. Slagle	Husband				Baltimo			
ore,	s 1 a of Hei Item		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla		Date	20c. Location		wn, State
Ĕ	Pages nent of l ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	Ce		11 Cemete		-17-2005	Brook]	Lyn, M	1D
Baltimore,	permit. Pages Department of P Important: if Ite any injury or of once.		21. Signaruh of Funer Nervice Licens	Pulsoro				mbrose F ng Rd.,			
	<i>91</i> /		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the de ne cause on each line.		er the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	Houte	mid	elle ce	relia	l Arter	y stro,	Ke	Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	•		/			
	LAGITITIO	1	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	I fen	ocan					year
V	ted nsit	nine	Cause (Disease or injury	Due to (or as a conse	equence or).					6	
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
8760,	e be de sicial	ical		4							
9	tificat ng phy as th										
). Box 6	Physicien: The law requires that the death certificate be executed tribic certificate hes been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	23c. ff yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	taf death 3	Ectopic pregnancy Other (specify)	у			ite of deliver	ny Day Year
P.O.	at the	Phy	9 Unknown					-24			
ŝ	rres th	by	Part II. Other significant conditions co	Remarks to about not re	ssuiting in the u	nderlying cause giv	en in Part I.		tobacco use con Yes 2 <sup>N</sup> Ø <sup>1</sup> No		e cause of death?
20	w require been sign	etec	Type Cyra	C - U ( 1)					^		ably 4 □Unknown
Records,	ne law hest ge 2 s	Completed						24a. Was	s an 24b. opsy ormed?	Were autop prior to con death?	psy findings available apletion of cause of
	n: Th ficate or, pag		Of Was seen released to medical					1 ☐ Yes	2 No	1 Yes	2 No
₹	s certi	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1  Inpatient 2	□ EP/Outpation	t 30 DOA Oth		eath Check only Home 5 Res	11.77	(0	11
Division of Vital	Attending Phy r death. ector: After thii by the funeral o		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			how intury occur		11405216
Divis	in Signature	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location City or To	(Street and Numi own, State)	ber or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tirvestigation, in my o	me, date and pla ppinion, death oc	ice, and due to the curred at the time	cause(s) and made, date and place,	anner as sta and due to	ated. the cause(s)
	To ti withi To ti	W	29b. Signature and title of certifier	my Wil	Den Ca	29c. Licens			29d. Date signe	•	* '
	V		30. Name indiaddress of person who of	ompleted cause of death (Ite	am 3a) (Type,	Print)	1 0		0 00		3,2005
_	Υ.		W. A Riles	JEBME	6701	N. Cl	Karle	ost. £	salto.	Mid	S(50)x
153	Sta	00.0	31. Date filed (Month, Day, Year)	32. Registrar's Sign		<i>d</i>					
17	Registr		men a na	005	M A						
DH	IMH 17 Rev 1/2	001	DE 6 % 0 2	A A A A A A A A A A A A A A A A A A A							

ORIGINAL

			State of Maryland / Dep	artment of Health and ertificate of Death	Mental Hygie	ene 2005	41063
	Di vivi		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici: /Medic		Mattie Agnes Smith		December	Î5, 2005	5:24 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  Catered Living	4b. City, Town, or Location of Dec Cockeysville	ath	4c. County of Deat	
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	) If Under 1 Year If Under 24 Hi	rs. 8. Date of Birth		
	Director		212-22-3613 1 M 2 X F 97 Yrs.	Months Days Hours Mi	April 1	1908 We	nplace (State or Foreign unity) St Virginia
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary Ff sho	tor	MD Baltimore Sparks				1 ☐ Yes 2 ☐ No
	or 28e	Jirec	10e, Street and Number	10f. Zip Code	100	. Citizen of What Co	untry?
	s 23e	by Funeral Director	1010 Cold Bottom Road	21152	(0)	USA	
	ter de Items	-une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	e, etc.
93	ours at	l by I	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1 ☐ Yes 2 🗖 No Specify:		Specify:	White
2-0	filed within 72 hours after death with the Maryland Hygiene. Sthat than: ant, the Medical Evand act must be notified at	Be Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 16	b. Kind of Business/	ndustry
7	within ene. than	dwc	Flementary/Secondary (0-12)   College (1-4or 5+)	etician		School Sys	tem
<u>م</u>	filed Hygi othar	Se Co	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma		
ylar	Menta Menta arked	To E	Wallace Fleshman	Sara			
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23e or 28e-f show mortant: If item 27 is marked othar than "natural; or items 23e or 28e-f show any injury or other traumatic avant, the Medical Examinat must be notified at once.		Norma Meier/daughter 19b. Mai	ing Address (Street and Number or I Cold Bottom Roa	<sup>Aural Route Number, 0</sup> d, Sparks,	City or Town, State, 2 MD. 211	
Baltimore,	of He of He of He or othe		20a. Method of Disposition  20b. Place of Disposition  1 X Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place)		c. Location - City or	
Ē	t. Pages tment of I tant: If its ijury or o		'4 □Donation 5 □Other (Specify) UUIaney	/alley Mem. Grdn.			
Ba	permir Depar Impor any ir		Myhol	$^{2}$ . Name and Address of Facility $$ R $$ $$ 1050 York Road,	Towson, MD	. 21204	Home, Inc.
į.	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	4	ac or respiratory arres	1 1	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	housen			25 ms
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ana o			ar jue
	scuted ind transii	Examiner	that initiated events c.			10	//
760,	be executed sician and burial-transit	ical Ex	Due to (or as a consequence of):				
687	ficate physics the	edica	d				
ŏ	The law requires that the death certificate be executed tile has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	,
O. B.	ie dea the att	/sicia		Other (specify)		Month	Day Year
α.	uires that the de signed by the a ld be detached f	Ph)	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	quires n sign	d by			1 ☐ Yes	2 No 3 □ Pro	babiy 4 Unknown
000	aw require	plete			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
	ding Physician: The lav h. After this certificate has funeral director, page 2 :	Completed			performe	d? death? ¶No 1 ☐ Yes	20 No
Zita Sita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?  Hospital:		eath (Check only one)		
o	Phys or this oral di	): To	27. Manner of Death 28a. Date of Injury 28b. Time		Home 5 Residence 28d. Describe how		ify)
ion	Attending or death. ector: After by the fune	atlo	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	To tha Hospital or Attent within 24 hours after deatl To tha Funaral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and planvestigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To tha within To tha comple	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month	, Day, Year)
,			Mul & Collen MP	119155		12/16/0	$\supset$
10	) T		30. Name and address of person who sopleted cause of death (Item 23a) (Type MANUL SICH PLAN NO D	Print) 16921 YONE	RD MO	NKTON Y	ND 24111
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 0 2005  32. Registrar's Signature	and t			/

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ORIGINAL

			ind / Depar	tment of Health a	and Mer	-	, ()	5 1	1064
		Decedent's Name (First, Middle, Last)				Date of Death Month	Day	Year	3. Time of Death
Physic /Med		IRWIN		SAMSON	DE	CEMBER		2005	2:00 A M
Exam		4a. Facility Name (If not institution, give street and number)	4	4b. City, Town, or Location	of Death		4c. Coun	ty of Death	
	Air	49 STIRRUP COURT	s. last birthday)	BALTIMORE If Under 1 Year If Under	24 Hrs o	Data of Righ	BAL	LIMORE	
Funera Directo		213-36-6329 ¹\dagged \dagged	, A	Months Days Hours	Min. 11	Date of Birth (Month, Pay, Ye /28/193	8	9. Birth	place (State or Foreign htry) MD
and		Usual Residence of Decedent  10a, State 10b, County 10c. 0	City, Town or Loca	ition				1	0d. Inside City Limits
r 28a-f ahow	Director	MD BALTIMORE	BALTIMOR	RE					1 □ Yes 2 No
vith th	Dire	10e. Street and Number		10f. Zip Code				f What Cour	ntry?
a 23e	ra	49 STIRRUP COURT	11.0	21208	:-:-0./0:		.S.A	ace - Americ	and India
1215-0036 within 72 hours after death with the Maryland nne. than "natural", or itema 23a or 28a-f ahow he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces? 1 Yes, Give X Year or Dates:		as Decedent of Hispanic Ori es, specify Cuban, Mexicar  Yes 2 No Specify:		an, etc.)		ack, White,	
Maryland 21215-0036 to 2 should be filed within 72 hours af thin and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exertitional Control of the Medical Exertition o	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kir lite. DC	nt's Usual Occupation nd of work done during mos O NOT use retired)	t of working	1		Business/In	dustry
rd 212: filed within the hygiene. other then	ပ်	5+	PHARMA				HARM		
should be file and Marked other marked other imatic avent,	To Be		SAMONOVIT	CH MAR	Y	irst, Middle, Mai		SAF	ERSTEIN
		19a. Informant's Name/Relationship (Type, Print)  NORMA SAMSON / WIFE		Address (Street and Number IRRUP COURT					Code)
0 0 0		20a. Method of Disposition 20b. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State MT V	. Place of Dispositi cemetery, crema	tory or other place)	Date			- City or To	
Baltimore, sermit. Pages 1 ar Department of Heal mportant: If Itam my injury or other page.		4 Donation 6 Donat (openly)	DETUI	CDAEL	2/18/2			RE, M	
Baltimo		21. Signature of Funeral Service Licensee	22. 1	Name and Address of Facili	ŠOL LE	VINSON	& BRO	)S., I	NC.
		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	33900	REISTERSTON	NEWALI	- PIKE	SVILI	E, NO	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	-	ailure					Onset and Death
/Medica Examine		resulting in death)  Due to (or as a conse	equence of):	<u> </u>					•
LAdmine		Sequentially list conditions, if any, leading to immediate							>10%
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	7400100 017.						
760, 4 be executed sician and burial-transit		resulting in death) Last  C.  Due to (or as a conse	equence of):						· · · · · · · · · · · · · · · · · · ·
1 w × 0	Ilcai	d							
Box 68760, sath certificate be evaluated attending physician for use as the buria	/Med	IF FEMALE: 23c. If yes, outcome of preg	inancy				224 0	ata of dollars	
Records, P.O. Box 68 The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as in	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	etal death 3 □E	ctopic pregnancy Other (specify)				ate of delive	Day Year
S, P es that igned to be deta	by P	Part II. Other significant conditions contributing to death but not re	,				-		ne cause of death?
cord  w require been si	ted	Ceretarovascular D	1 Sease			1 🗆 Yes	2 <b>N</b> o	3 Prob	ably 4 □Unknown
. 42 07	Somple	Hypertension				24a. Was an autopsy performed 1 Yes 2 ₩	17	. Were auto prior to condeath?	psy findings available inpletion of cause of 2 No
f Vita ysician: is certific director,	Be (	25. Was case referred to medical examiner?			of Death (C	heck only one)	_		
of Vita Physician: this certific	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 I  27. Manner of Death 28a. Date of Injury				5 Residence			y)
Sion tending leath.	tion	27. Manner of Death 1	28b. Time of Injury	28c. Injury at Work?  M 1 Tyes 2 T		Describe how i	njury occi	irrea	
Division  Hospital or Attendid  24 hours after death.  Funeral Director: A etely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Countries)				Location (Stree City or Town, S		ber or Rura	l Route Number,
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical C	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my king the pass of examiner: On the basis of examiner and manner stated.	nowledge, death o	occurred at the time, date an stigation, in my opinion, dea	l nd place, and ith occurred a	due to the caus it the time, cate	e(s) and n and place	nanner as si	ated. the cause(s)
To the within 2 To the complet	Mec	one) and manner stated.  29b. Signature and title of certifier		29c. License number		29d.	Date sign	ed (Month,	Day, Year)
- 3 - ŏ		May Behrer , 1	15	D3874	17		_	16-0	-
15		30. Name and address of person who completed cause of death (Ite	om 22a) /Tuna Pr						
Par since e	tate								
Regis		31. Date filed (Month, Day, Year) 32. Registrar's Sig	Course.						

SAID TO BE IRWIN SAMSON

			1 - For State Registrar	State of Man		artment of Health a rtificate of Death	R	eg. No. 2 U U 5	41065			
	Physici		1. Decedent's Name (First, Middle, Las FOUNIAIN TURNS	_	-		2. Date of Deat Month	Day Year	3. Time of Death			
>	/Medic Examir		4a. Facility Name (If not institution, give FREDRICK VILLA	street and number)		4b. City, Town, or Location of CATONSVILLE		4c. County of Dea	th			
	Funeral Director	1	20.56.2020		n yrs. last birthday) 32 Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Birth (Month, Day, 08 · 28 · )	9. Bir <b>9. 3</b>	thplace (State or Foreign ountry) GA			
	f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  ND N		Oc. City, Town or Lo				10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
:	with the	Director	10e. Street and Number	/ENUE		10f. Zip Code 21216	1	0g. Citizen of What Co	ountry?			
036	72 hours after death with the Maryland natural; or Itama 23a or 28a-1 ehow dical Examirar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Original Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify: BLI	e, etc.			
2121	liene.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most DO NOT use retired) NG ASSISTANT	of working	16b. Kind of Business				
⊆ .	e da la B	To Be	17. Father's Name (First, Middle, Last) MACK I. TURNER			ESSIE	r's Name (First, Middle, M CORBIN					
	1 and 2 s dealth ar sm 27 io ther trau		19a. Informant's Name/Relationship (18 BERNADETE TURNE 20a. Method of Disposition	R (DAUGHTE	2) 5127	FREDERICK AVE	. BALTIMORE	E MD 213	129			
Baltimore,	Page nent o snt: if		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cemetery, crematory or other place)  WOODLAWN  12-17-05  BALTIMORE, MD									
Ba	Departr Departr Imports any inju		23a. Part1. Enter the disease, or com	J	51	2. Name and Address of Facility UGHN C. GREENE F 51. BAUD. NATU PINCE ter the mode of dving, such as	BAUD. MD :	21229	Approximate			
	Physician // Medical system and paral-transit the parial-transit the p	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c	consequence of):  PCRTEN onsequence of):	IL INFARC	Non		Interval Between Onset and Death Onset and Death Onset of DAY			
BOX 6	death certifi e attending I d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2[ 4□ Pregnant at tin 9□ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year			
	quires that n signed by uld be deta	ρ	Part II. Other significant conditions of DEMENTIA	ontributing to death but r	not resulting in the u	nderlying cause given in Part I.	23e. Did tot	pacco use contribute to	o the cause of death?			
	The law requires that the sate as been signed by the page 2 should be detached.	Completed	CERBBRO VA	scular 1	ACCIPEN	Τ	24a. Was a autops perforr	prior to death?	utopsy findings available completion of cause of			
Vıta	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatier	1 au A	of Death Check only on		cutu)			
IVISION	or Attending fler death. Director: After in by the fune	Certification: T	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  2 Homicide  5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Y	28b. Time o Injury	f 28c. Injury at Work?  M 1 □ Yes 2 □ f	28d. Describe ho	ow injury occurred				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of rainer: On the basis of each and manner state	kamination and/or in	h occurred at the time, date and vestigation, in my opinion, deat	l d place, and due to the ca th occurred at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)			
l	To the within To the compli	Me	29b. Signature and title of certifier	e bi		D. 3 c 46		9d. Date signed (Monte	th, Day, Year) \$, 2005;			
	3			850, COL4	KBIA, 10		+ 308, Col	umbia. 1	10.21045			
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	A Ances	K s						

			1 - For State Registrar	State o	f Marylan		artment of F		nd Menta		ene 2005	41066	
9	Physici	an.	1. Decedent's Name (First, Middle,	Last)					M-	ate of Death	Day Yes	3. Time of Death	
	/Medic		Herbert		В.	Tur	ner			12	17 2005	6:56p \	1
	Examin	er	4a. Facility Name (If not institution, 2448 Brentwood	-	mber)			timore			4c. County of D NA	eath	
	Funeral	00	,	6.Sex 1527M 2□ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Da Min. (M	te of Birth lonth, Day,	9. I	Birthplace (State or Foreig Country)	חו
办	Director		220-20-4772 Usual Residence of Decedent	X 23.	77	Yrs.				10-7-2	28	Md.	
	land m		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	S
	Mary -f sh	ō	Md. NA			Baltin	nore					1X1Yes 2 □ No	0
	1 the	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of What	Country?	
	13a o		2448 Brentwood	Ave.			2121	8			USA		
	deeti	ner	11. Marital Status		edent Ever in U.	.S. 13.	Was Decedent of H	lispanic Origi	in? (Specify Y	es or No-		merican Indian,	
9	after or Ite	F	1 ☐ Never Married 2 ☐ Marrie		2 No		1 □ Yes 2 □ No	Specify:	ruello nican,	<del>9</del> (0.)	Specify:	/hite, etc.	
8	ural',	d b	3 Widowed 4 □ Divorced	Year or E	ates:		7 103 2 X 110	opeony.			Зреспу.	Black	
2	natu	Completed by Funeral	15. Decedent' (Specify only highest			(Give	dent's Usual Occup kind of work done	during most of	of working	11	6b. Kind of Busine	ss/Industry	
12	withing and the state of the st	ш	Elementary/Secondary (0-12)	Coltege (	1-4or 5+)		DO NOT use retired	<i>3)</i>			Reliable	Liquors	
2	Hygie ther	ပိ	8th grade 17. Father's Name (First, Middle, L	ast)		W	arehouse	18. Mother	's Name (First		aiden Sumame)	птфаогъ	
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mantal Hygiene. Is marked other than "natural", or Itema 23e or 28e-f show aumatic event, Ite Medical Exaction must be rediffed at	э Ве	John	,	Turne	r		Ros		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Carte	r	
₹	ges 1 and 2 should t of Health and Men If Item 27 is marke or other traumatic	P L	19a. Informant's Name/Relationsh	ip (Type, Print)	1 01110		ng Address (Street			e Number,	City or Town, State	e, Zip Code)	_
2	D 5 ~ 3		Patricia Wither		aughter		Radecke						
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tra		20a. Method of Disposition		20b. P	The second second second second	sition (Name of natory or other place		Date		Oc. Location - City	or Town, State	
E	Pages nent of P ant: If Ito ury or of		Unit Burial 2 ☐ Cremation Donation 5 ☐ Other (Sp		State		Forest V	1	2-23-05		Owings M	ills, Md.	
<u>=</u>	permit. Departm Importa sny inju		21. Signature of Funeral Service L	Ga	ss of Facility			incre, Md. 21202					
<u> </u>	20E # 8		Dlady	won	ب	М	arch F.H.	. East	110	Î E.	North Av	e.	
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that only one cause on	caused the deat	h. Do not ent	er the mode of dyin	ng, such as ca	ardiac or resp	ratory arres	st,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		L 1	ung	Conc	e2				Onset and Death	,
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	LXammer	_	Sequentially list conditions, if any, leaving to immediate	b	(or se a conego								
	led isit	Examiner	Cause (Disease or injury	20010	(O) as a concept	danes ory.							
	axecu al-tra	xar	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
8760,	cate be executed physician and the burial-transit	dicai E		d =====									
68	ifficate g phys as the	edic									1		
Вох	death certifica attending phater use as t	N/UE	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy	,			23d. Date of	,	- }
П	that the death cer ed by the attendin detached for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)				Month	Day Year	
P. 0.	at the	Phy	9 Unknown							0. 0.1			
ŝ	ires tha signed d be det	by	Part II. Other significant condition		eath but not resi	-		en in Paπ I.	2.	3e. Did toba 1⊠Yes	_	e to the cause of death?  Probably 4 □Unknown	
5	w requir been si should	eted	1 1 1 1 1 1 1 1 1	V 1/300	0,70	3 (7)2			1/20	103	20140 30	Trobably 4 Dorkhow	
Division of Vital Record	elaw hast je 2 s	Completed							24	4a. Was an autopsy performe	prior	autopsy findings available to completion of cause of	θ
<u></u>	t: Th icete r, pag								1[		No 1 Y		
₹	siciar certif recto	Be c	25. Was case referred to medical examiner?	Hospital:		2010	t 3 DOA Oth	00	of Death (Che				_
o	Phy irthis arald	To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of	1 JU DON	4 🗀 14013			ce 6 Other (S	pecify)	
o	ding f th. : After s funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Mon	th, Day Year)	Injury		k? Yes 2.∐No			. ,		
NIS.	Atter	ifice	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place			eet, factory, office					Rural Route Number,	
Ö	safter safter al Dire	Certification:	4   Homicide	bulla	ing, etc. (Specify	у)			Ci	ty or Town,	State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours atterd death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier 1 Certifying	Physician: To the examiner: On the b	e best of my kno	wledge, death	occurred at the tir	ne, date and	place, and du	e to the cau	ise(s) and manner	as stated.	_
	the Phin 24 the F	Medi	one)	and man	ner stated.				. zasanou at ti				
١	Viti To Con	~	29b. Signature and title of certifier	01	In in	20)	29c. Licens	o number	_		d. Date signed (Mo	onth, Day, Year)	
	11/		19/ Milhe	my per	1								1
10	1 -		30. Name and address of person v	completed cau	se of death (Item	( //-	Charles	St.	Balli	me	12120	4	
1,00	Sta	te	31. Date filed (Month, Day, Year)	32. F	ngistrar's Signa	iture	ask)					,	
	Registr		DEC 2	0 2005	September .	13. 19	Carried Control						

			Please	State of Mondand			•	9
			1 - State Registrar	State of Maryland /	Certificate		Mental Hygier	
			Registrar  1. Decedent's Name (First, Middle, Las	s#1	Certificate	or Death	Reg.	
н	Physici	an	0 0		, ,			Day Year 3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give		which the City I	own, or Location of Deat	MERZIEL	16 doos 7A.M. M
	Examin	er	1 ~					
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. last t	birthday) If Under 1		<ul> <li>8. Date of Birth</li> </ul>	3Allimoret 9. Birthplace (State or Foreign
	Director		1 1686 46 216	OM ZOF TH	Yrs. Months	Days Hours Min.	JAN-8 193	
	ը ,		Usual Residence of Decedent				10.11.0	
	show	_	10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits
	8a-f	Director	MARXAMO BALTIME	suoi sin				1 ☐ Yes 27 No
	with t	Ē	10e. Street and Number	11-1-0	10f. Zip 0		10g. (	Citizen of What Country?
	s 23	rai		文井130公		31304		U.S.A.
	ter de Item	Funerai	11. Marital Status 1 ☐ Never Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 240 No	If Yes, specif	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	hours after death with the Maryland ture!', or Items 23e or 28a-f show at Examinant be nuffited at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify: \ 1) 1
21215-0036	n 72 hours after death with the Marylan "naturel", or litems 23e or 28a-1 show after Exactiner mant be notified at		15. Decedent's Ed		a. Decedent's Usual	Occupation	16b.	Kind of Business/Industry
218	be filed within 72 hc ital Hygiene. id other then "natul event, the Medical	Completed	(Specify only highest gra	College (1-4or 5+)	life. DO NOT use	done during most of wo retired)	rking	
21	filed withir Hygiene. other then rent, the M	Con	107Rs-		Homemak	KER		AT Home
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)	11 0		18. Mother's Na	ne (First, Middle, Maid	en Sumame)
yla	should be t ind Mental I s marked or umetic eve	은	Fron 1.	VARLEY		VIRE	inia Si	HIFFLET
Maryland	2 8 3	11	19a. Informant's Name/Relationship (7	Type, Print)	9b. Mailing Address (	Street and Number or Re	ural Route Number, City	y or Town, State, Zip Code)
	s 1 and 3 t Health item 27 other tr		20a. Method of Disposition	20b. Place	of Disposition (Name	PLACE #1	303 10050 Date 20c.	Location - City or Town, State
20			T⊠Burial 2 ☐ Cremation 3 ☐	Removal from State cemet	tery, crematory or oth	ner place)	19,	Cocation - Oily of Town, State
Baltimore,			'4 □ Donation 5 □ Other (Specify 21. or ure of Furera 3 wice Licen	See GAY	EAS OF FA		105 Kps	MERIE 1 STATES
Ba	permit. Departr Importe any inje		188 484		2 DARYS	Address of Facility	OAD PORK	2112 Magn 2012
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	Dications that caused the death. Do		77 7 7 7 7 7 7		Approximate
	Pnysician :		Immediate Cause (Final	Renal F				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a consequence				
	Examiner		Commencially lies are distance	A therosc	lenche	Vasculor	D158651	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):			
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
760,	oe exectan sourial		resulting in death) cast	Due to (or as a consequence	e of):			
687	ys 9	dical	•	d				
× 6	ding se as	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal deal	th 3 □Ectopic prec 5 □ Other (spec			23d. Date of delivery  Month Day Year
o.	that the de ad by the detached	Physician/Medi	1 ☐ Yes	9☐ Unknown		//		
۵.	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	by PI	Part II. Other significant conditions co	ontributing to death but not resulting	in the underlying cau	use given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	w require been sig should b						1 ☐ Yes	2 No 3 Probably 4 □Unknown
000	aw re s bee 2 sho	Completed					24a. Was an	24b. Were autopsy findings available
Ä	The lavate has	E O					autopsy performed?	
Vital		BeC	25. Was case referred to medical			26. Place of Dea	ath (Check only one)	10 163 20 140
_f	S S	ToE	examiner? 1 ☐ Yes 🚜 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA	Other: 4 Nursing H	lome 5 Residence	6 ☐ Other (Specify)
D 0	ng Ph fter th ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b. (Month, Day Year)	Time of 280 Injury	c. Injury at Work?	28d. Describe how in	ury occurred
Sio	Attending r death. sctor: After by the funer	cati	2 Accident investigation		М	1 Yes 2 No		
	or At after d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory,	office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
	Hospitel of hours all Eunerel D		29a. Certifier	uninima. To the beet of my language	go dooth account to	Abortion data and data		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only one)	ysician: To the best of my knowledge liner: On the basis of examination a and manner stated.	ge, death occurred at and/or investigation, in	n my opinion, death occu	rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	./	29c.	License number	29d. D	Pate signed (Month, Day, Year)
)	. ,		1 /50	aucott		00 5041	1	2005 PINSDMS
	12		30. Name and address of person who		(Type, Print)	- 11	. [22]	-E1, (MAL) 1 0000
_	10	-	JOHN ANCOH	, MD 10755 FO	alls Ko,	, Luttenvil	le, mo	21093
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Societas.			

			For State Registrar	State of Maryland / Depa Cei	artment of Health and Natificate of Death	Mental Hygie	00014 600				
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death				
	Physici /Medic		JOHN JACKSO	1 TREADWILL I	77	1	Day Year SILEPMM				
	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death				
			1344 BYAN ROAM		FALLSTON		HARFORD				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M 2□ F	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar)  9. Birthplace (State or Foreign Country)				
	Director		521 39 9146	M 2 F Yrs.		002.1103	TRESCHUSETT H				
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits				
	Many f ah	Į.	Coolon Harris	) FRULS			1 ☐ Yes 2 No				
	the	Director	10e. Street and Number	7 14779	10f. Zip Code	10g.	Citizen of What Country?				
	3a o		1344 RYAN ROG	$\sim$	21chr		1200.				
	death	Funerai			Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,				
ဖွ	after or Ite	Fu	1 Never Married 2 Married	1+©Yes 2 □ No		Rican, etc.)	Black, White, etc.				
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 ahow to Madical Ezaminal", ust be mallified at	d by	3 SWidowed 4 □ Divorced	Year or Dates: VITAGA	1 ☐ Yes 2 No Specify:		Specify: WHITE				
2	natu	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business/Industry				
12	withir ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		5 00 V				
0 0	filed withi Hygiene. other thar ant, Its y		17. Father's Name (First, Middle, Last)	T 3(12-	18 Mother's Nam	e (First, Middle, Majo	In Sumama				
an	Mental Mental arked o	Be C		READWILL	_		\				
Maryland	2 should and Menia is marked	2	19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Run		Y or Town State Zin Code)				
Š	C		SHAWA M. HYDE	19 Ar		WITA A	METI PIDAYLYZON				
	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition	20b, Place of Dispo	sition (Name of		Location - City or Town, State				
<b>Baltimore</b> ,	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	natory or other place)	os Fo	200 kga ( 11.4 - 20				
a E	permit. Pag Department Important: I any injury o		21. Sundare of Funeral Service License	22	Name and Address of Facility	182 L - BU	Air, P.A. 21050				
m	permi Depa Impo any iu		May Note	= 2	NEW PORT DRIVE	FOREST	MILL MARYLAND				
	Prrysician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
			Immediate Cause (Final disease or condition resulting in death)  a. Mctustatic NonSmallCellLungConcer								
			resulting in death)	Due to (or as a consequence of):		110-1 // //(0/1)W.					
	Examiner		Secuentially list conditions b.								
7	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
V	ecut and I-tran	хап	that initiated events c.	Due to (or as a consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ai E		5 45 (5) 45 4 551150Q501155 (1).							
687	ficate phys s the	dicai	d.								
ŏ	eath certific attending p I for use as	/W	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy			23d. Date of delivery				
$\mathbf{m}$	death s atte	iciai	in the past 12 months?	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month Day Year				
о. О.	that the de led by the a detached t	hys	9 Unknown	9□ Unknown							
	res tha iigned be det	by Physician/Me	Part II. Other significant conditions conf	ributing to death but not resulting in the ur	iderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?				
ğ	w require been sig should b	ed				1)XIYes	2 No 3 Probably 4 Unknown				
Records,	has be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
_		Com				performed?	death?				
Vital	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)					
7	Phyais this o	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatien		me 5 Residence	6 ☐Other (Specify)				
n o	ding P. h. After I	ion:	27. Manner of Death  17 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred				
<u>S</u>	tend death tor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be	DO Physical Articles (1)	M 1 Yes 2 No						
Division of	l or Attendater deati	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	City or Town, Sta	and Number or Rural Route Number, ate)				
	spital ours peral filled		29a. Certifier TA Certifying Physi	cian: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause	(c) and manner as stated				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Examin	er: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)				
	To th within To th comp	Me	29b. Signature and title of certifier	2 /1	29c. License number	29d. [	Date signed (Month, Day, Year)				
			Live x/5	raimor MI	D0051777		TONGERIA JONE				
	12		30. Name and address of person who cor	npleted cause of death (I - m 23a) (Type, I	Print)		11				
	10	ال	Julie K Brahm	erMD 1650 Orl	earsStreet B	altimore	Maryland 21231				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	P		į.				
	uedisti		nfr. 2. 0 2005	Description of the second							

			For Stata			nd / Depa	artmen	t of H	ealth a	and M	ental Hygi		gible.	1.1000		
Ragistrar Certificate of Death Rag. No. 000 4 10										41007						
	Physicia	an	<ol> <li>Decedent's Name (First, Middle, David J. Tiren</li> </ol>	Last)							2. Date of Death Month Day Year					
	/Medic	al					AL CIL	T	(haster)	( De este	Decembe	ecember 18, 2005 4:15 A M				
	Examin	er								4c. Co	unty of Deat					
			Charlestown Re 5. Social Security Number	tirement S. Sex	7. Age (In yrs.	last hirthdayl	Catonsvill If Under 1 Year   If Under 24 Hrs.				9 Date of Birth		Baltimore			
	Funeral Director		081-24-6806	1∭ M 2□F	74	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year) 1931	New	hplace (State or Foreign untry) York		
	ס		Usual Residence of Decedent				ll				108. 0,			10210		
	rylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo		_						10d. Inside City Limits		
	e Ma Sa-f s	cto	MD B	altimore			Cato	nsvi	ille		γ			1 ☐ Yes 2 XNo		
	or 24	Funeral Director	10e. Street and Number				10f. Zip					-	of What Co	•		
	s 23e	ra	713 Maiden Cho						1228				ed Sta			
	er de Itam	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed F	edent Ever in U orces? 2 No 194	13. 13. 149.	Was Deced If Yes, spec	lent of Hi cify Cubai	spanic Ori n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No- Rican, etc.)		Race - Ame Black, White	e, etc.		
36	irs af	by F	3 Widowed 4 □ Divorced	If Yes, Gi	ve .		1 ☐ Yes	2X No	Specify:			Sp	ecity: Wh	ite		
ŏ	2 hou	ted	15. Decedent	Education		16a, Dece	dent's Usua	d Occupa	ation		1		of Business/	Industry		
2	thin 7 9. an "n	ple	(Specify only highest Elementary/Secondary (0-12)	ř	1-4or 5+)	life.	kind of wor DO NOT us	se retired,	uring mos. )	t of workir	ng		ional			
7	ad wil	Completed	12	1		Ar	nalyst	5						Agency		
p	ba filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Itams 23e or 28e-f show event, the Medical Exertener instituted at	Be (	17. Father's Name (First, Middle, L	ast)							(First, Middle, M	laiden Sui	mame)			
<u> </u>	ould Men Marka Parka	유	Harry Leroy Ti								s Schwab					
Nar	12 sh and r is m raum		19a. Informant's Name/Relationsh				-				Route Number,					
e,	1 and 4ealth sm 27		Craig Tiren S  20a. Method of Disposition	on	20h	ZU313			5Tα T		ce, Germ		ion - City or			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Event and injury or other traumatic event, the Medical Event and integral of once.		1 Burial 2 □ Cremation		State MD	coverers	THY C		ery							
를	iit. Partme artme ortani injury	1	' ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service I		A 10/1	Growns		d Addres			-2005 rose Fun		nsv <b>i</b> ll			
Ba	permi Depar Impo any ir	1	Data Maria	7	Dat	Contract of the Contract of th					Rd., Ar					
			23a. Part1. Enter the disease, or o	omplications that	caused the dea								J, 111	Approximate		
	Pnysician		Onset and Dea										Interval Between Onset and Death			
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a										YEARS			
	P =	ner														
6	acute ind trans	Examiner	Causa Classes or figure that initiated events c. resulting in death) Last Due to (or as a consequence of):													
, 092	ate be executed hysician and the burial-transit	Ê	1990(iiig iii deaiii) Last	Due to	(or as a consec	quence ot):										
687	physic	dical		d												
9 ×	ding se as	/Me	IF FEMALE:	23c. If ves. ou	itcome of pregn	ancv						224	Date of deli			
Вох	that the death certifica ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	aldeath 3	Ectopic pr Other (sp					230.	. Date of deli Month	Day Year		
o.	the d ny the ached	lysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nown									32		
<u>ت</u>	res that igned b	by PI	Part II. Other significant condition	s contributing to	leath but not res	sulting in the u	ndertying c	ause give	n in Part I.		23e. Did toba	acco use	contribute to	the cause of death?		
ğ	w require been sig should b	ed t									1 ☐ Yes	2 □ N	lo 3 🗆 Pro	obably 4 Mnknown		
Records,	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	plet									24a. Was an		4b. Were au	topsy findings available		
ž	: The law cate has	Completed									autopsy perform 1 Yes 2	ed?	death?	completion of cause of		
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					77.	26. Place	of Death	(Check only one	-		<i></i>		
of <	Physician: this certific ral director,	2	1 ☐ Yes 2 No			ER/Outpatier	100	tria de	4 1300	rsing Hon	ne 5 🗆 Resider	nce 6 🗆	Other (Spec	cify)		
n	ing P	on:	27. Manner of Death 1 Watural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury		8c. Injury Work	?		.8d. Describe how	v injury od	curred			
Sic	Attanding r death. actor: After by the funer	icat	2 Accident investig	ot be	a of laiune. At h	ama form at	M		res 2 □ l		194 Location /Str	not and M	umbor or Ou	ral Route Number.		
Division	or Atlantation or Atlantation Dirac	Certification:	4  Homicide determin	ned 286. Place build	e of Injury - At h ling, etc. <i>(Speci</i>	fy)	eet, ractory	, onice			City or Town,		umber or Au	rai Houte Number,		
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certification is the funeral director, the funeral director, the funeral director.		29a. Certifier 1 Certifying	Physician: To th	e best of my kn	owledge, deatl	h occurred	at the tim	ie, date an	d place, a	ind due to the car	use(s) and	manner as	stated.		
	e Hos 24 h e Fur letely	edical		xaminer: On the b	asis of examination	ation and/or in	vestigation	in my op	oinion, dea	th occurre	ed at the time, da	te and pla	ice, and due	to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier	, ,	^/			License			-		gned (Month			
•			) M.	· V	100	0		DY	474	18	D	ECE	MBER	18,2005		
	4		30. Name and address of person v	no completed cau	se of death (Ite	m 23a) (Type,	Print)									
	0		MATTHEW J.	Norr									···-			
	Sta Registr		31. Date filed (Month, Day, Year)	32.1	Registrer's Sign	ature	home	200								
	negisti	ui .	DEC	2 0 2005	De to spiller	9 8 m	1									

			1 - For State Registrar	State of Maryland / D			-	ne 2005	41070
	Physic	ian	Decedent's Name (First, Middle, Last)  T	mi			Date of Death     Month	Day Yea	3. Time of Death
	/Medi		Jerome	Thomas			December	11, 200	5 5:40 P M
4	Exami	ner	4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town,	or Location of Death		4c. County of D	
	Funeral		4607 Linden Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. last birti		Halethorp If Under 24 Hrs.		9, 1	Baltimore  Birthplace (State or Foreign
	Director		220-56-1083	2□ F 54 Y	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 1,	1951	Country) Maryland
	pug 🔏		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryla f sho	ō	MD Baltin			thorpe			1 ☐ Yes 2X No
	28a-	Funeral Director	10e. Street and Number		10f. Zip Code	1	10g.	Citizen of What	
	h with	<u>=</u>	4607 Linden Avenue			21227		Jnited S	
	ams	ner	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cub				merican Indian,
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give	1 ☐ Yes 2 🛣 No		ritoari, oto.)	Specify:	White
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jisal Examirar must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Year or Dates:	Decedeni's Usual Occu	nation	161	. Kind of Busine	
215	nin 72 In "na Madic	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Give kind of work done life. DO NOT use retire	during most of worki	ng		ssirioustry
21	od with	mo	12	2	Electroni	c Model Ma	ker	efense Depa	rtment
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Mai		
Z̄.	Men Men Marka Marka	Į,	Gordon Thomas			1	th Kurucz		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	19a. Informant's Name/Relationship ( <i>Type</i> , Lydia Thomas Wife		Mailing Address (Stree				
	1 an Heal tam 2		20a. Method of Disposition	20b. Place of	07 Linden A Disposition (Name of			MD 212: Location - City	
<u>0</u>	Pages ent of nt: If i		1 Burial 2 ☐ Cremation 3 ☐ Rem  '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	, crematory or other pla Park Cemet	· 1	0005	.1timore	
Baltimore,	mit. F partm portar r injui	1	21. Signature (1 Funeral Serves, Licentaria	Doudon Company		ess of Facility Amb			
Ö	Depa Impo any ir	1	( ) when we	WY 1001301	1328 Sulph	nur Spring	Rd., Arb	utus. M	21227
A	law requires that the death certificate be executed as been signed by the attending physicien and as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Examiner	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of the case of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	CANC	-0	r respiratory arrest,		Approximate Interval Between Onset and Death Comonths
P.O. Box 68760,		Physiclan/Medical	d  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	3 □ Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of o	delivery Day Year
Records, F	w requires that been signed should be det	þ	Part II. Dther significant conditions contrib	uting to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did tobaco		to the cause of death?  Probably 4 □Unknown
al Reco	The ate h	Completed					24a. Was an autopsy performed 1 Yes 2	? prior t	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:	O#	26. Place of Death		Y	
of	Phys or this aral dir	To To	T Tes 2 ANO	28a. Dale of Injury (Month, Day Year)  28b. Ti	ALIBITE 3 DOA	4 U Nursing Hon	ne 5 X Residence 8d. Describe how in	6 □Other (S)	pecify)
ion	ttanding F death. ctor: After y the funera	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inj		rk? ]Yes 2□No			
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8f. Location (Street City or Town, St	tion (Street and Number or Rural Route Number, or Town, State)				
	To the Hospital or A within 24 hours after To tha Funaral Dirac completely filled in by	edical	(Check only	an: To the best of my knowledge, On the basis of examination and and manner stated.	or investigation, in my o	opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To T Com	2	29b. Signature and title of certifier	fo 110	29c. Licens	(12-11	29d.	Date signed (Mo	nth, Day, Year)
,	1		, we	ace MID		16354	12	112/2	1005
	り		30. Name and address of person who comp	STAGNES 40	ype, Print) O CATON	AVE BA	LTIMORE	EMD	21229
	Sta Registi		31. Date filed (Month, Day, Year)  DEC	32. Registrar's Signature	A Ana	26 D			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M		d / Depa		of He	alth a		lental Hy	giene	005	41071
		Ţ.	Hegistrar     Decedent's Name (First, Midd.	le, Last)			imodic	0, 0	Cutii		2. Date of De			3. Time of Death
	Physici: /Medic		Mary -	Thompson							Decen	ber	Year 15 2005	M S A PS O M
	Examin		4a. Facility Name (Il not institutio				4b. City, To	. 1 .				4c.	County of Dea	ath
-	Funeral		5. Social Security Number	1050: 1A1	je (In yrs. i	ast birthday)	If Under 1	/ear	If Under 2	24 Hrs.	8. Date of Bi	th	9. Bi	rthplace (State or Foreign
	Funeral Director		218-28-3046		72	Yrs.	Months D	ays	Hours	Min.	8. Date of Bir 07-2-1	933°	Man	yland
	and		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl	tor	MD Baltin	nore	Ba1	timore	Highl	ands	5					1 ☐ Yes 2 ☑ No
	th the or 28a	lrec	10e. Street and Number				10f. Zip Co					10g. Citi	izen of What C	ountry?
	s 23c	Funeral Director	3007 Michigan A			_ ],	2122					U.S.		
	fter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Decedent Armed Forces?		S. 13.	Was Deceden If Yes, specify	t of Hisp Cuban,	Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi	
9500-91212	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23c or 28e-f show ant, it a Musical Exacting frast by recilified at		3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		0	1⊡Yes 2 <del>√</del>	] No	Specify:			8	Specify: W	nite
ב	n 72 h "natu	Completed by	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usual ( kind of work of DO NOT use	occupati done dui	ion ring most	of worki	ing	16b. Ki	ind of Business	s/Industry
717	d within jiene. r than	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	Home		0.1100)				Own	Home	
פ	should be filed within 72 hours after death with the Marylan ad Mendal Hygiens.  marked other than "natural", or flems 23s or 28e-1 show marked other than "natural", or flems 12s or 28e-1 show marked other than "natural".	BeC	17. Father's Name (First, Middle,	*							(First, Middle	, Maiden	Sumame)	
Maryland	should be nd Mental marked c	2	David Carruther			401 14-10		-	Edna		-	- 0		7: 0 ()
<u></u>	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relations Linda Stevens/I								nore MD		r Town, State, 27	Zip Code)
Baitimore,			20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from State	20b. P	lace of Dispo emetery, crer	sition (Name natory or othe Vetera	of r place)	1		Date	20c. Lo	ocation - City or	r Town, State
Ĕ	permit. Pages 1 Department of H Important: If ite any injury or ott		`4 □ Donation 5 □ Other (S	Specify)	Cem	etery	@ Crow	nsvi	ille	12-2	20-2005	Cro	wnsvill	e, MD
e C	permil Depar Impor any in		21. Sinnature of Funeral Service	Licensee	18	A A	Mbrose	Fur	of Facility	Hon	ne of L	ansd	owne owne MD	01007
	3,		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	the death	n. Do not ent	er the mode of	itilitio I: of dying,	such as	cardiac c	or respiratory a	rrest,	owne ML	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	1		inour	110	Vn.	300	P	SMAOL			Onset and Death  Amonths
		er	resulting in death)	Due to (or as										3
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):										
	cuted nd ransit	Examiner	that initiated events											
/60,	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):											
289	ficate physics the t	edical		d										
XOR	h certi ending r use a	an/M	IF FEMALE: 23b. Was d <i>ec</i> edent pregnant	23c. If yes, outcome			Ectopic preg	nancy				2	23d. Date of de	
o O	es that the death certifica igned by the attending ph be detached for use as th	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (speci						Month	Day Year
ב	that the	/ Ph	Part II. Other significant conditi	ons contributing to death t	out not resu	ulting in the u	nderlying cau	se given	in Part I.		23e. Did 1	obacco u	se contribute t	o the cause of death?
Kecords,	The law requires that the te has been signed by th bage 2 should be detache	ed by	CRB, DH	1, Ashn	4						1 🗆	Yes 2[	PNo 3□P	robably 4 Unknown
ဝင္ပ	law re las bee	Completed									24a. Was	DSV	prior to	utopsy findings available completion of cause of
												2 No	death?	s 2□No
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  W	Hospital:	ent 2 🗍	ER/Outpatier	nt 3□ DOA	Cther:			Check only		6 □Other (Spe	ngifu)
סר		on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date of Inju		28b. Time of		Injury a Work?			28d. Describe			ochy)
DIVISION OF	Attendir death. ctor: Af	catle		igation			М	1 🗌 Ye	s 2 🗆 N		204.1	0		
<u> </u>	el or Attendi s after death. st Director: A od in by the fu	Certification;	4 Homicide determ		ic. (Specify	me, rarm, str	eet, ractory, o	TICE			City or To			lural Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	edical C	29a. Certifier 1 ☐ Certifyi (Check only 2 ☐ Medical	ng Physician: To the best Examiner: On the basis of	of my kno	wledge, deatl	n occurred at a	the time,	, date and	d place, a	and due to the	cause(s)	and manner a	s stated.
	thin 24 thin 24 the 5 mplete	Medi	one) 29b. Signature and title of certific	and manner st	ated.			icense r			ou at the time,		e signed (Mon	
	F 3 F 8		NO.	. M. 1x		10	1	) _ (		10				
	5		30. Name and address of person	who completed cause of	death (Item	23а) (Туре,	Print)			- \		LCC.	ember	15,2005 House, MD
	/		31. Date filed (Month, Day, Year	51:55, MD	rar's Signa	(bor H	latiques	3	200	2. 17	19 novel	St	1/a/l	Home, MD
	Sta Registr		or. Date med (Month, Day, 19a)	0 2005	B. J. J.	4	ale							
			DEC D	H / HUJ - AMERICA	TATTOWN OF	-								

State of Maryland / Department of Health and Mental Hygierie ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eugene Τ. Urbaniak December 2005 12:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore. 10 Ratna Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Hours Min. Feb. 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F 1944 Maryland 218-42-6304 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 22 - 1 any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Ratna Court 21236 u.s.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Dept. of Defense Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Urbaniak Helen Rogalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Urbaniak (wife) 10 Ratna Ct., Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 12/22/05 Baltimore, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. art1. Enter the disease, or comunications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deay Gastro-Esophagoal Junction Immediate Cause (Final disease or condition resulting in death) **Physician** arcinolua /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐Unknown 1 Yes 2 No peeu s 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jecember 19 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21239 5601 Loch Raven 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 ZUUD

			For State Registrar	State of Maryland	d / Depa		lealth and M	Mental Hygie	_	5 41073
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Everett Ernest Voe     4a. Facility Name (If not institution, give supper Chesapeake N	treet and number)		4b. City, Town, c	or Location of Death	2. Date of Death Month 12	Day Yea  11 200  4c. County of D	65 1109 M
	Funeral Director		5. Social Security Number 6. Sex 215-52-0896			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		Birthplace (State or Foreign Country) Maryland
Maryland 21215-0036	De lied within 72 routs are reading last Hygiene 23 d other than "naturel", or fleme 23 event, the Medical Exertiner mus	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  Md.  Harford  10e. Street and Number  724 High Plain Dri  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Adam Voelker  19a. Informant's Name/Relationship (Typ. JoAnn Marie Voelke	LVe  2. Was Decedent Ever in U.S. Armed Forces?  1  Yes  2\tilde{\text{No}} \ \text{No} \ \text{If Yes, Give Year or Dates:}  cation \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	16a. Deced (Give life. poli	Bel Air  10f. Zip Code  2.  Was Decedent of If Yes, specify Cub  I Yes 2 No  dent's Usual Occup kind of work done DO NOT use retire  ce office	pation during most of word d)  2  18. Mother's Nam Marie and Number or Ru	pecify Yes or No- p Rican, etc.)	Black, W Specify:  Sb. Kind of Busine  1 aw enfo iden Sumame)	merican Indian, thite, etc. white ss/Industry rcement
12/ Baltimore,	rage ment clant: If		20a. Method of Disposition  1 Burial 2 Cremation 3 Report Specify)  21. Signature of Funeral Service License	Be1	Air I		ess of Facility Funeral			Md. Inc.
334021 760,		Ical Examiner	23a: Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	ARTE  CARD	ng, such as cardiac RY DI	SEASE  PATITY	t,	Approximate Interval Between Onset and Death CARS
0. Box 68	the attending phy ched for use as the	ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
EVeret #	rne law fequires that in cate has been signed by page 2 should be detac	Completed by Physiclan/Med	HYPERTENS	SE	lting in the u	nderlying cause gr	ven in Part I.	23e. Did tobar  1  Yes  24a. Was an autopsy performe 1 Yes 2	2 No 3 = 24b. Were prior death	e to the cause of death?  Probably 4 □Unknown  autopsy findings available to completion of cause of ?  es 2 ☑ No
l $l$ $l$ $l$ $l$ $l$ $l$ $l$ $l$ $l$	2 2 2 2	Certification: To Be	25. Was case referred to medical examiner?  1  Yes		ER/Outpatier 28b. Time o Injury me, farm, str	28c. Inju Wo M 1	ner: 4 □ Nursing H ry at	th Check only one ome 5 Residence 28d. Describe how 28f. Location (Stre City or Town,	injury occurred	(pecify)  Rural Route Number,
a side	io the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one)  1  Certifying Phys 2  Medical Examin  29b. Signature and title of certifier	ician: To the best of my knover: On the basis of examinating and manner stated.	viedge, deati ion and/or in	vestigation, in my	opinion, death occu se number	rred at the time, date	and place, and o	onth, Day, Year)
	O Sta		30. Name and address of person who co LESTER LEVNG  31. Date filed (Month, Pay Year)	mpleted cause of death flem , MD 520 (	PPEK					ER 13, 2005 BELAIR MB, 4

			1 - For State Registrar	State of Maryl	and / Depa	artment of F	lealth an Death		giene 0 0	5 41074
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Thomas W. Vane					2. Date of Dea Month De cembe	Day	Year 1905 PM
	Examir		4a. Facility Name (If not institution, give st ST AGNES HOSP			46. City, Town, o			4c. County	of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 216-62-6174		yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth Min. Jan. 9,	1954	9. Birthplace (State or Foreign Country) Maryland
36	be filed within 72 hours after death with the Maryland that Hygiene do ther than "naturel", or items 23e or 28e-f show event, the Marklant Examination and the motified at	by Funeral Director	MD N/A  10e. Street and Number  1625 South Ellamon	t Street  2. Was Decedent Ever Armed Forces? 1 — Yes 2 (20 No) IYes, Give		Baltim	1230	? (Specify Yes or No- uerto Rican, etc.)		1 States - American Indian, k, White, etc.
Baltimore, Maryland 21215-0036	e filed within 72 hours al Hygiene. I other than "naturel" vent, the Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired Pump Oper	du <i>ring most</i> of d)	f working		siness/Industry nore City Department
yland 2	2 should be filed and Mental Hygi Ie marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Bernard G. Vane				18. Mother's Joan	Name (First, Middle, C. Hodges		
re, Mar	Health and tem tom 27 le m		19a. Informant's Name/Relationship (Typ  Joan C. Vane Moth  20a. Method of Disposition	er	1625 Db. Place of Dispo	S. Ellam	ont St	reet, Balt: Date	imore, N	
Baltimo	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic and any injury or other traumatic and any injury or other traumatic and any injury or other tra		1 Burial 2 Dermation 3 Re 4 Donation 5 Other (Specify) 21. Signature Funeral Service Line	1	Bayview (	Name and Addre	, Inc.	12-14-05 Ambrose Fun	neral Ho	ome, Inc.
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68760, 🦑	licate be executed physician and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor						
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ō	Physician: this certificant ral director, in	.To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatier		4	ng Home 5 Resid		
sion	Attending I r death. ector: After by the funer	cation	Natural 5 Pending investigation	(Month, Day Yee		Wor	k? Yes 2 □ No			
Divis	s after de s after de sl Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stopecify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical		ician: To the best of my er: On the basis of exa and manner stated.						
<b>\</b>	To the To the comp	Me	29b. Signature and title of certifier	M.D.		29c. Licens	e number			(Month, Day, Year)
	3		30. Name and address of person who could be keyur kum Ar	npleted cause of death	(Item 23a) (Type,	Print)		TIMORET		
P.	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature					

Registrar

DHMH 17 Rev 1/2001

VANE, THOMPS

DEC 2 0 2001 Janes 15: April

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			Registrar  1. Decedent's Name (First, Mid.	lla lasi	-1		00,	TillCati	e or i	Death	1 3	2. Date of De	Reg. No	0.	3. Time of	Death
	Physicia /Medic		Richard James	Vhyt	e						I	Month	er l	2, 2005	6:40	P <sup>M</sup>
	Examin	ıer	4a. Facility Name (If not instituti		street and nu	mber)		l .		r Location o	of Death			c. County of Dea		
			304 Rockdale Co 5. Social Security Number	6. Se	x	7. Age (In yrs	. last birthday)	Fred If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	dh	rederic		or Foreign
14	Funeral Director		170-30-7213		<b>∑</b> M 2□F		9 Yrs.	Months	Days	Hours	Min.	(Month, Di	av. Year	936 Pen	thplace (State o ountry) nsv1van	ia
	P.		Usual Residence of Decedent													
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Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relation	ship (T	уре, Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rural	Route Numb	er, City	or Town, State,	Zip Code)	
	D = ~ =	1 3	Carol Whyte, w	lfe			304 R	ockda	le C	ourt,				ryland	21702	
ore	Pes 1	1 3	20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation	3 □1	Removal from	State	Place of Dispo cemetery, cre			1 1	2/17/	1005		Location - City or		
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	Attending Physician: The law requires that the death certificat reads.  r death.  sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant			tcome of pregr		7-						23d. Date of de	livery	
P.O. Box	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No			birth 2 ☐ Fet nant at time of		⊒Ectopic pr ⊒ Other (sp						Month	Day	Year
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5	s cert	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	Inpatient 2	T FR/Outpatie	nt 3 🗆 DC	Oth Oth	00		(Check only		6 ☐Other (Spe	ecify)	
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Š	endin sath. or; Af	atic	Z	tigation			,,	М		Yes 2 🗌	No					
Division of Vital Records,		Certification:	3 Suicide 6 Cou 4 Homicide dete	mined	280. Plac	e of Injury - At I ling, etc. <i>(Sp</i> ec	home, farm, st afy)	reet, factory	y, office		28	8f. Location ( City or To		and Number or R te)	lural Route Num	iber,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #20b Per FH G850 P2/2007019 OHDeath Reg. No. U U 5 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 13, 2005 /Medical give street and number. 4c. County of Death Town, or Location of Death Examiner NA OSDITAL 8. Date of Birth (Month, Day, (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Yrs. GA 05.21.1932 <u> 257. 42.8155</u> Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show rthan "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 1 No **Funeral Director** MD HOWARD COLUMBIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9556 WOODBUCK ROW 21045 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DIRECTOR OF SECURITY CLIFTON T. PERKINS HOSP. 1214 GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filt ment of Health and Mental H tant: If item 27 is marked ott DELLA MAE HART HENRY CLINTON WATSON ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 i MARGARET WATSON (WIFE 9556 WOODBLOCK ROW, COLUMBIA MD 21045 20b. Place of Disposition (Name of Crowns verification Character) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 12.21.05 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST OWINGS MIUS, 21. Signature of Funeral Service Licer VAUGHN C. GREENE FUNERAL SERVICE augh 5151 BALTO. NATE PIKE BALTO. MD 21229 Approximate
Interval Between
Onset and Death
O DAYS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEMORRHAGE Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Records, P.O. detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2X No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Cther: 1 Ainpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation Natural after death. 2 □ No 1 Tyes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) icai 29a. Certifier and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062448 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State DEC 2 0 2005 Registrar

NAVAL NEBRAT 31. Date filed (Month, Day, Year)

GOD N. WOLFE STREET, BALTIMORE, MD 21887 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene
Amend Items# 6 & 20a per FH G850 12/20/05 Officiate of Death Reg. 40.005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** BURNARO WELLES 12 15 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA MI IMORE CITY CARCE Furine HUMEWUW) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 11 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours Months Yrs 220-14-9568 79 Director Md. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside-City Limits item 27 is marked other than "natural", or items 23a or 28a-i show other traumatic event, the Medical Examinar must be notified at Baltimore 1 1 Yes 2 □ No Md NA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21218 USA Funeral Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ۾ Black 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist American Coat Pads 12th grade 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health end Mental Hy Important: if item 27 is merked otherny injury or other traumetic event 18. Mother's Name (First, Middle, Maiden Surname) Be Wells James Allen Sylvia Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sylvia Wells Daughter 6540 Falkirk Rd., Apt. C , Baltimore, Md. 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat. Cem. 12-22-05 Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner JAK16m nutrition physiclan end s the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of) for use es Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ð page 2 should be 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was en autopsy Completed performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No After this certificete funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Qutpatient 3 ☐ DOA 27. Manne of Death 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by or A 4 Homicide e Hospital of 24 hours e Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 29b. Signature and title of certain 29c. License number 29d, Date signed (Month, Day, Year) MO 30. Name en address of person who completed cause of death (Item 23e) (Type, Print) 1000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ford

Registrar

DEC 2 0 2005

				For State Registrar	State of	f Maryland	/ Depa	artment of F	lealth and M Death		ene ()	5 1	1078
		Di		1. Decedent's Name (First, Middle	le, Last)					2. Date of Death Month	Day	Year	3. Time of Death
		Physici /Medio		GREGORY MICHAE						Decomb	1 20	2005	19:20 HM.
		Examin	er	4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		4c. County	of Death	
				Baltimore-Wash: 5. Social Security Number		ical Cen 7. Age (In yrs. las		Glen Bu	rnie   If Under 24 Hrs.	8. Date of Birth	Anne	Arun	
		Funeral Director			1 <u>⊠</u> M 2□F	45	Yrs.	Months Days	Hours Min.	(Month, Day,			ace (State or Foreign try)
				214-48-0856 Usual Residence of Decedent						April 22	1900	Maryl	and
		nylan show	_	10a. State 10b. County			Town or Lo					10	Od. Inside City Limits
		the Marylan 28a-f show	Director	2	ne Arundel	Pa	sader						1 ☐ Yes 2,☐,No
		vith th	Dire	10e. Street and Number				10f. Zip Code		10	g. Citizen of \	What Count	try?
		s 23e	erai	1626 South Sho		dent Ever in U.S.	12.1	21122	lanania Orinina (Con		nited	State	
		ter de Item	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Mar	Armed For	rces?	13.1	f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		ck, White, e	
4	036	urs a	by	3 Widowed 4 Divorced	If YAS GIV	e <sup></sup>		1 ☐ Yes 2 ☐ No	Specify:		Specify	√ Whi	te
WEBER	2-0	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show he Medical Examinar must be notified at	Completed	15. Deceder	nt's Education est grade completed)			dent's Usual Occup	ation during most of worki	1	6b. Kind of B	usiness/Ind	ustry
E.	21	vithin ne.	mpje	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	DO NOT use retired	1)				
*	121	iled w Hygiei ther ti	S	12 17. Father's Name (First, Middle,	(act)		Mari	ne Mecha	nic 18. Mother's Name		Boatin		
	Maryland 21215-0036	d be f intat h ed ol	Be	George E. Web								10)	
3	<u> </u>	shout nd Me mark	2	19a. Informant's Name/Relations			19b. Mailin	ng Address (Street	Virginia and Number or Rura			State, Zip	Code)
Ã		nd 2 alth a 27 is		Virginia Weber	/Mother		1626	South Sh	ore Parkw	ay Pasad	ena, M	D 21	122
THE GOLLY	Baltimore,	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any njury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 → Barial 2 ☐ Cremation	0	20b. Pla	ce of Dispo	sition (Name of natory or other place	Dec.	ate 2	0c. Location -	City or Tov	vn, State
SE	<u><u><u></u></u></u>	Page ment ant: If ury o		'4 □Denation 5 □Other (5	Specify)	JIAIO		n Mem. P	1		len Bu	rnie,	Maryland
5	ä	eparti. eparti nporti ny nj		21. Signature of Euperal Sa vice	License		22 K i	. Name and Addre	ss of Facility				
		ŭ □ ⊑ ≅ a		Taloury					ddick Fund Hwy. S.E.			MD 2	1061
_				23a. Part1. Effer the disease, o shock, or heart failure. List Immediate Cause (Final	r complications that ca t only one cause on ea	aused the death. ach line.	Do not ent	er the mode of dyir	g, such as cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	a. LW	hosis	3/-1	Nen					
		Examiner			Due to (	or as a conseque	nce of):						
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4	, 0	ate be execute hysician and the burial-trans	Ex	resulting in death) Last	Due to (	or as a conseque	nce of):						
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	9 ×	certific inding p use as	/Me	IF FEMALE:	23c If yes out	come of pregnanc					224 5-4		
	Bo	eath certif attending I for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bi	irth 2 ☐ Fetal d ant at time of dea	eath 3	Ectopic pregnancy Other (specify)			Z3d. Dai	te of deliver nth [	y Day Year
	0	that the de ed by the detached	hysi	1 Yes 2 No 9 Unknown	9□ Unkno	wn							
	Division of Vital Records, P.O. Box	S C 0	by Physician/Med	Part II. Other significant conditi	ons contributing to de	ath but not result	ing in the ur	nderlying cause giv	en in Part !.	23e. Did toba	acco use cont	ribute to the	cause of death?
	ord	equire en sig	ted							1 🗆 Yes	2 □ No	3 Proba	bly 4 Unknown
	ecc	ne law require s has been sig ge 2 should b	Completed							24a. Was an autopsy		prior to com	sy findings available pletion of cause of
	<u>=</u>	: The cate h								perform 1 Yes 2	ed?	death? I□Yes 2	
	Vit.	ding Physicien: The h. h. After this certificate h. funeral director, page	Be	25. Was case referred to medica examiner?	Hospital:			t 3 DOA Oth	26. Place of Death		)		
	of	Phys r this ral di	To To	1 Yes 2 No 27. Manner of leath	1 130		Outpatien  Bb. Time of			ne 5 🗆 Resider			
	on	nding F ith. : After e funera	atior	1 Natural 5 Pendii 2 Accident investi	ng (Monta igation	h, Day Year)	Injury	Wor	k? Yes 2□No				
	Vis	ol or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 200. Place	of Injury - At hom ng, etc. (Specify)	e, farm, str	eet, factory, office	2	8f. Location (Stre	et and Numb	er or Rural	Route Number,
		itel or irs afte rel Dir led in			Jonan								
		To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical	ng Physician: To the Examiner: On the ba	sis of examinatio	edge, death n and/or inv	occurred at the tir restigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau and at the time, dat	use(s) and ma se and place, a	nner as sta and due to t	ted. the cause(s)
		o the ithin 2 o the mplel	Med	one) 29b. Signature and title of certifie	and manr	er stated.		29c. Licens	e number	29	d. Date signed	d (Month. D	lay, Year)
	<b>\</b>	F ₹ F 8		AW		Pw.		A W	617		م دادها	24	705
		i		30. Name and address erson	who completed cause	e of death (Item 2	• 3a) (Type.	Print)	7111	12	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	4 4	1000
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		Registr	ar	DEC 2 0 21	005	JAN 1	Contract of the second						

State of Maryland / Department of Health and Mental Hygiene 05 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Marcia P. Wilkins December 17, 2005 12:44A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month Day, Year) April 24,1937 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 68 Yrs. 1 □ M 25 F Director 001-26-3585 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits r then "natural", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 787 Martin Court West 21144 **USA** Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Self Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1e marked othe eny injury or other traumatic event, since 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Schein Ada Malamud 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 787 Martin Court West Severn, Maryland 21144 Michael C. Wilkins, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/19/05 Baltimore, Maryland 21. Signature of Fyneral Service 19 see Thomas Gregor <sup>22, Name and Address of Facility</sup>
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE **Physician** days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events WIKINS, Mare 1a 12-17-05 0049 Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lar Vasculitis 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PLC 2 No P 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2/ Accident after death 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Director completely filled in by ti 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified alll D 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) endall 6601 N. Charles Street taullener MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			for State Registrar	State of Marylar		nt of Health and te of Death	d Mental Hy	giene 05 4	1080
	Physici		1. Decedent's Name (First, Middle, Las	"Waldrap	·		2. Date of De Month		3. Time of Death
	/Medic Examin Funeral Director	7 1	4a. Facility Name (If not institution, give Franklin Square 5. Social Security Number 6. S 212 28 4404	HOSDIHAL CE	nter R	CSCADE or 1 Year If Under 24 I Days Hours N	eath	4c. County of Death BAI+IMORE Th ay Year) 9. Birthpla County 11, 1930 Maryl	Cace (State or Foreign by) Land
	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exacilizar most be notified at	Funeral Director	10a. State 10b. County  Maryland Baltimor  10e. Street and Number  627 Tampa Road			p Code 21221		10g. Citizen of What Country USA	d. Inside City Limits 1 □ Yes 2 □ No ry?
21215-0036	2 hours after deal ature!; or Items ;	Ď.	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed	12. Was Decedent Ever in U Arged Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, sp 1 ☐ Yes	ual Occupation	uerto Rican, etc.)	14. Race - Americar Black, White, et Specify: Whit	tc. Ce
	filed within 7 Hygiene. other than "n ent, me Med	Completed	(Specify only highest gra  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NOT Clerk			Pet Shop	)
Maryland	2 should be f and Mental is is marked or aumatic eve	To Be	Madison Lloyo	Type, Print)	19b. Mailing Addres	Naon	i Tripp	Der, City or Town, State, Zip C	Code)
	Pages 1 and 2 nent of Health a int: If item 27 Is		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	Removal from State	Place of Disposition (No cometery, crematory or Lawn Ceme	other place)	Date	20c. Location - City or Town Baltimore, Ma	
Baltimore,	permit. Pages 1 and Department of Heall Important; If item 2 any injury or other 2008.		4 Donation 5 Other (Specification of Foreral Service Liberature of	,	22. Name a	and Address of Facility	Bruzdzir	nski Funeral H Essex Maryland	Home PA
8760,	death certificate be executed  Medical  Examine and physician and prior rase as the burial-transit	lical Examiner	23a. P. 11 Enter the disease, or or mock, or heart failure. List my Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	blication that caused the deal one cause on each line.  a. FENAL FAI  Due to (or as a consect  Due to (or as a consect  C. ALMENTA  Due to (or as a consect  Due to (or as a consect  d. d.	TUPE (upence of):	de of dying, such as car	diac or respiratory a	irrest,	Approximate Interval Batween Onset and Death
.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 Ectopic			23d. Date of delivery Month D	y Day Year
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Ž	Physician: this certific ral director,	To Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 [	Cthor	Death (Check only	one) idence 6 Other (Specify)	
ion of	ding After fune	ertification: T	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work?		how injury occurred	
Divis	in Pile o	O	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Special	fy) 		City or To	(Street and Number or Rural F wn, State)	
	e Hospital 24 hours a Funeral letely filled	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or investigation	n, in my opinion, death o	occurred at the time,	cause(s) and manner as stat , date and place, and due to the	he cause(s)
	To the P within 2 To the P	Me	29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Month, Da	ay, Year)
7	97		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	NOUS ZOS N Square Ds		12/18/05 ZIZ3	37
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa		La sala	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

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	E		Decedent's Name (First, Middle, Last)	2	t. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Carl Rudolph Wursthorn		December	18, 2005	8:30 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			9213 Samoset Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Randallstown  If Under 1 Year   If Under 24 Hrs.   8	. Date of Birth	Baltimo	ore place (State or Foreign
	Funeral Director		1X M 2□F O/ Yrs	Months Days Hours Min.	(Month, Day, Yo	ear) Cou	Germany
4	ס		Usual Residence of Decedent		орт, о,		
	arylan ahow	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits 1 ☐ Yes 2 X No
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	within 72 hours after death with the Maryland ene. then "natural", or itams 23a or 28a-f ahow he Madical Exama nust be multibut at		10e. Street and Number	10f. Zip Code	109.	. Citizen of What Cou	ntry?
	ns 23	Funeral	9213 Samoset Road  11. Marital Status  12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	USA 14. Race - Ameri	can Indian,
(0	ifter d	Fun	Armed Forces?  1 Never Married 2 Married 1 NY 9s 2 No If Yes, Give		can, etc.)	Black, White,	etc.
8	rai', o	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🔀 No Specify:		Specify: Wh	ite
5	"natu	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working	16	b. Kind of Business/Ir	ndustry
2	within ane. than	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		MD Nationa	1 Cuerde
0	Hygie Hygie Ither I		17. Father's Name (First, Middle, Last)	18. Mother's Name (i			ir Guarus
an	ld be ental kad o	To Be	Carl R. Wursthorn	Anna	Kirla		
Maryland 21215-0036	shou and M s mar umat	-		ing Address (Street and Number or Rural F		City or Town, State, Zij	Code)
Σ	and 2 salth a n 27 is			Samoset Road Randa	1		
altimore,	of He of He if itan		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of Datematory or other place)	te 200	c. Location - City or T	own, State
Ē	Pag ment tant:		`4 □Donation 5 □Other (Specify) Garrison	Forest Vet Cem 12/2			
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any righty or other traumatic event, the Markeal Exprirent rust be notified at once.		1	22. Name and Address of Facility 1182			
	40 = 80		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	ELINE FUNERAL HOME I			21136 Approximate
ŀ			shock, or heart failure. List only one cause on each line.			1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	- Heart for	,//	-	
*:	Examiner						
М		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cuted nd ransit	Examiner	that initiated events C.				
Ö,	e exe ian au urial-t	EX	resulting in death) Last Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed as been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d				
9 ×	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of deliv	00/
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	Day Year
P.O.	that the de led by the a detached f	ysi	1 Yes 2 No 9 Unknown				
	s that ned b e deta	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
Records,	equire en sig		Deneta		1 ☐ Yes	2₽No 3□ Pro	bably 4 Unknown
000	law re as be	plet			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
	The ate ha	Completed			performe 1 ☐ Yes 2 ☐	d? death?	
/ita	clan: ertific	Be	25. Was case referred to medical examiner?	26. Place of Death (	Check only one)		
Division of Vital	Physi this c	To	1   Yes 2 2 No		d. Describe how		fy)
uc	ding I n. After funer	tlon	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	d. Describe now	injury occurred	
isi.	Attending Physiclan: sr death. actor: After this certifics by the funeral director, t	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s			et and Number or Run	al Route Number,
<u> </u>	al or A after i Dira d in b	erti	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
	ospitu hours unara ly fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea				
	To the Hospital or Attanding Physiclan: The law requires tha within 24 hours after death.  To tha Funaral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	ledical	one) and manner stated.				
	To To	Σ	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month,	uay, rear)
	N 8			727123		2119/01	
0	10		30. Name and address of person who completed cause of death (Item 23a) (Type	7	and a	~3 Z 1131	
	Sta	te.	31. Date filed (Month, Day, Year)  32. Registrar's Signature	)1		7 2114	
	Regist		DEC 2 0 2005 Brown &	porte			

			For State	State of Ma	aryland	-	artment of tificate of			-	giene Reg. No.	005	410	82
	- 1		1. Decedent's Name (First, Middle, La	ist)				Doda		2. Date of De	ath		3. Time of	Death
	Physicia		JOHN	WISE						Month DE Œm∉	Day SFR.	19 2005	172	5 PM
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town,	or Location		0		County of Deat	1	
		•	NORTHWEST	HOSPITAL	_		RAT	SPALL	STOWN	~		BALTIN	ORE	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year Months Days		or 24 Hrs. 8	B. Date of Bir	th v. Year)	9. Birtl	nplace (State ountry)	or Foreign
	Director		217-26-5584	1 🛣 M 2 🗆 F	75	Yrs.	World S Days	7,0010	J	(Month, Da	2,193	0	MD	
	pur *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation						10d. Inside C	ity Limits
	fanyla f sho	ŏ											1 Tyes	•
	28e-1	Director	MD Baltimo  10e. Street and Number	re	O	vings	Mills 10f. Zip Code				10a Citiz	zen of What Co	untry?	
	with B or		1 B Trolod Cou				211	1 7			rog. Onia		and y :	
	ns 23	era	1 B ITOTOG COU	12. Was Decedent	Ever in U.S.	13.			Origin? (Spec	ify Yes or No	- 1	USA 4. Race - Ame	ican Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heatih and Mental Hygiene. Item 27 ie marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 1  If Yes, Give Year or Dates:		i i	Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 🛣 No			ican, etc.)		Black, White		
ğ	2 hou	ted	15. Decedent's E	ducation		16a. Deced	ient's Usual Occu	pation			16b. Kin	nd of Business/	ndustry	
Maryland 21215-0036	vithin 7 ne. hen "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done DO NOT use retin	ed)	ost or working	g	T1.	1	. D	
i K	iled v Hygie ther t nt, in		17. Father's Name (First, Middle, Las	2		. ע	river	18 Mot	her's Name	(First, Middle,		her Aut	o Part	S
and	d be i	Be c	James I. Wise	,				70. 1110				andlev		
<u>_</u>	should Me mark mati	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Num	Eve]				ip Code)	
Š	od 2 still ar		Kevin P. Wise	Son			9 E. Cha							36
Ē,	f Healthean other		20a. Method of Disposition		20h Plac	e of Disno	sition (Name of natory or other pla		Da	te		cation - City or		J0
OE.	Page ent o nt: If ry or		1 ☐ Burial 2 XCremation 3 ( 1 ☐ Donation 5 ☐ Other (Special Control C			-	Crematio	· 1	12/21,	/05	и	lampstea	d M	
altimore,	pernit. Pages 1 and Deportment of Healt Importent: If item 2 any injury or other once:	1	21. Signature of Funeral Service Lice	nsee	Julia		. Name and Addr					isterst		ad
0	89 5 8 8		Stephen ?	n Jens	~	] ]	Eline Fu	neral	Home			town, N		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each lir	the death.	Do not ent	er the mode of dy	ing, such a	s cardiac or	respiratory a	rrest,		Approximat Interval Bet	ween
4	Physician		Immediate Cause (Final disease or condition	. 100	Lower	del	inta	ctrien					Onset and	Death 1
K	/Medical Examiner		resulting in death)	Due to (or as	consequer	nce of):	0						- y	
	Examiner		Sequentially list conditions,	b	encl	X	arem						da	So
	ed isit	line	if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	Due to (or as	a consequer	nce or):							-	£3.
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):								
8760,	siclar buris	dicai E		d										
687		<b>a</b> ) +		<b>C</b> 0.										
.O. Box	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregnand Other (specify)				2	3d. Date of deli Month		Year
Φ.	res that tigned by	/Ph	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the u	nderlying cause g	ven in Par	t I.	23e. Did t	obacco us	se contribute to	the cause of c	leath?
rds	v requires been sign should be	ed by								10	Yes 2□	No 3□Pro	bably 4	Ínknown
Division of Vital Records,	ne law requ s has been ge 2 shoul	Completed								24a. Was		24b. Were au prior to d death?	opsy findings ompletion of c	available ause of
a			05.11							1 Yes	2XNo	1 🗆 Yes	3.00 No	
₹	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	2 7 5 5	2/Outpation	t 3 DOA			Check only o		□Other (Spec	26.3	
o	Attending Physician: r death. ector: After this certifics by the funeral director, i	H- 1	27. Manner of Death	28a. Date of Inju	ry 28	Bb. Time of	28c. Inju	ury at		e 5 Hesit 3d. Describe I			iry)	
lon	nding ith. :: Afte	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Injury		ork? ]Yes 2[	□No					
N N	or Attencafter death Director: In by the	ifice	3 ☐ Suicide 6 ☐ Could not determined		ury - At home	e, farm, str	eet, factory, office	)	28	If. Location (S City or Tox	Street and	Number or Ru	ral Route Num	ber,
Ö	tel or s afte el Dir ed in	Certification:	4 El Homoldo	building, etc	o. (Opachy)					Only of 100	err, Diate)			
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination	edge, death n and/or in	occurred at the vestigation, in my	time, date a opinion, de	and place, an eath occurred	d due to the	cause(s) a date and	and manner as place, and due	stated. to the cause(s	)
	To the To the Complet	Me	29b. Signature and title of certifier	and manner ste			29c. Licer	ise numbe	r		29d. Date	signed (Month	Day, Year)	
	- 9 - 8		A much	• <b>△</b>	2		T	2005	9736		0.	enker !	9 200	****
	1		30. Name and address of person who		e:	За) (Туре,			.,,0	4		men !	1, 500.	
)	•		~ 2		·	NDR-	The 100 E 0 E	HOS	PITAL	5401	06	-p cou	RT R	0.00
	⇒ 🥫 Sta	* -9	31. Date filod (Month, Day, Year)	32 Registra	ar's Signatur	e /o	ele							
	Registr	ar	DEC 2 0 2	32/Registro	" تناجم الها	1								
CULT	MIL 47 Day 470	201		97										

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland			of Death	F	leg. No:	005	41083
	Physicia		1. Decedent's Name (First, Middle, Last) Stella Reven	White				2. Date of Dea Month 12	Day	Year 2005	3. Time of Death 8:00 A M
S. Carlot	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, To	own, or Location of Death	12	<del></del>	ounty of Death	
	Funeral Director		8112 Huntmaster Co 5. Social Security Number 6. Sex 212-05-9980	Ourt 7. Age (In yrs. las. 91	t birthday) Yrs.	If Under 1 Months	Glen Burnie Year II Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day 11/1/1	r, Year)	9. Birth	Arunde1 place (State or Foreign ntry) VA
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	fown or Lo	cation					10d. Inside City Limits
	Maryi -1 sho	tor	MD Anne An	cunde1			Glen Burnie				1 ☐ Yes 2X No
	or 28s	Director	10e. Street and Number	direct		10f. Zip C			10g. Citizer	n of What Cou	ntry?
	a 23a		409 Phelps Avenue	2. Was Decedent Ever in U.S.	12 1	Nac Docado	21060	ecty Ves or No-	14	Race - Ameri	SA can Indian
036	itled within 72 hours after death with the Maryland Hygiene. Wher than "naturel", or Itema 23a or 28a-f show wit, the Medical Exambrat must be molified at	by Funeral	11. Marital Status  1 Never Married	Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		f Yes, specifi	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto XNo Specify:	Rican, etc.)		Black, White	
9200-612	n 72 hours naturel', adical Exe	eted	15. Decedent's Educ	ation completed)	16a. Deced	dent's Usual kind of work	Occupation done during most of work retired)	ing	16b. Kind	ol Business/Ir	ndustry
	within ane. Ihan	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use Homen				0	Hama
מ		0	17. Father's Name (First, Middle, Last)	2		пошеш	18. Mother's Nam	e (First, Middle,	Maiden Su	Own (mame)	Home
Jan	\$ 0 th 0	To B	Andrew J. Shiflet				Sydnia	L. Bree	den		
Maryland 2	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Typ	e, Print)			Street and Number or Rur				
	of Health item 27 other tr		Mr. Elliott White 20a. Method of Disposition	20b, Plac	e of Dispo	sition (Name	ps Avenue,	Glen B		e Mary tion - City or T	land 21060 own, State
ē			MXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	natory or oth n Mem.	10.0	22-2005	Glen	Rurni	e. Maryland
Baltimore,	permit. Page Department Important: If eny injury or once.		21. Signature of Funeral Service License	e		. Name and	Larie	ingleton	Fune		me, P.A.
			23a. Part1. Enter the disease, or complic shock, or neart failure. List only on	cations that caused the death. e cause on each line.	Do not ent	er the mode	of dying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition resulting in death)	NECK	CAN	ICER	?				Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):						
		Jer	Sequentially list conditions, a least 15 in relate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of						
	ficate be executed g physicien and is the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last							_	
60,	be exe		resulting in doubly East	Due to (or as a conseque	ice or):					1	1
68760	= 0.0	edical	- d	-							
D. Box	The law requires that the death certifice has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALÉ: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. II yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3	Ectopic pred Other (spec			230	d. Date of delive Month	rery Day Year
, P.O.	res that the de signed by the a be detached t	y Ph	Part II. Other significant conditions con	tributing to death but not resulti	ng in the u	nderlying ca	use given in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sign should be	ed by	Hyps thyron	215m				1 🗆 Y	'es 2 🗂 1	No 3□ Pro	bably 4 □Unknown
Reco	The law re ste has bee	Completed						24a. Was a autop perfor	med?	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
/ita	cien: ertifica ector.	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Deal	1.000		Gra	nddaughter's
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ospital: 1  Inpatient 2  EF  28a. Date of Injury (Month, Day Year)	VOutpatier Bb. Time of Injury		Other: 4 Nursing Ho c. Injury at Work? 1 Yes 2 No	ome 5 Resid 28d. Describe h		Uther (Speci	(h) Residence
Divisi	al or Attendi s after death. Il Director: A id in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	reet, factory,	office	281. Location (S City or Tow		Number or Rur	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (		ician: To the best of my knowler: On the basis of examination and manner stated.							
	withi To ti	Σ	29b. Signature and title of certifier	all a			License number	1		signed (Month,	
,	1			Manyon)_	0-1-5	1	754574		12	2/19/	/2005
1	2		30. Name and address of person who co	mpleted cause of death (Item 2	GLSI	V BUR	NE Mp o	21061			
	Sta		31. Date filed (Month, Day, Year) DEC 2 0 2	32. Registrar's Signatur	G A	Coule	NIE Mp				
	Regist	ar	DE U & U 4	UUU JEGGESS S	6 1	7					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** December 15,45 Winn Patricia 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Yrs 217-40-9070 4,1941 Director Nov. Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 271s marked other than "neturel", or Iteme 23a or 28a-f ehow ury or other traumatic event, the Modical Examination to notified at 1X Yes 2 No Directo Baltimore City Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 United States 1300 Broening Highway Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cowan Trucking Co. Accounts Receivable 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Martin Alvis Cameron Winn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Maryland 21220 1910 Mars Run Road (Nephew) Chris McComb 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 12/20/2005 Middle River, Maryland 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final Massive **Physician** myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☑ No 9 ☐ Unknowh 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has L lirector, page 2 s autopsy performed 1 ☐ Yes 20 No To the Hospital or Attending Physicien: octor: After this certific by the funeral director. 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Under the cause (s) and place, and due to the cause (s) and place, and due to the cause (s). 29a. Certifier cai (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier clover 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) mnixea eLovac 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 0 2005 Registrar

		-	For State Registrar	State of Marylan	-	artment of H			ne 005	41086
			Decedent's Name (First, Middle, Last)				1	2. Date of Death		3. Time of Death
	Physicia /Medic	al -		Eck Zwanz	ig			December		2 P. M
	Examin	er	4a. Facility Name (If not institution, give s 8504 Valleyfield			4b. City, Town, or Luther			4c. County of Death Baltimor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i	ast birthday)	If Under 1 Year		B. Date of Birth		place (State or Foreign ntry)
	Director		219-05-0479	M 20XF 8	Yrs.	Months Days	Hours Min. A	B. Date of Birth (Month, Day, Y Ugust 20	, 1917 Mai	rÿland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryl Hebe	to	MD Balt	imore	Luther	ville				1 ☐ Yes 2 💢 No
	th the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
	ath will		8504 Valleyfield			21093			U.S.A.	
936	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow the Medical Exactinat must be mallfed at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces?  1	1	Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2★ No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa	luring most of working	7	b. Kind of Business/Ir	ndustry
21215-0036	i within 72 ho jiane. r then "natur ir e Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired, memaker			Own home	
d 2	be filed with tal Hygiene. d other thei event, Ire		17. Father's Name (First, Middle, Last)		110	IIIEIIIAKEI	18. Mother's Name (	First, Middle, Ma		
lan	should be fand Mental Family marked of	To Be	Andrew	Eck			Edna		Brown	
Maryland			19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a	and Number or Rural	Route Number, C	City or Town, State, Zi	o Code)
	D = C =		Jeanne V. Sittler			Valleyfi	eld Rd., I		.lle, MD 2	21 093
Jore	Pages 1 nent of P int: If its iry or ot		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ R	omeual from State	emetery, crer	natory or other place			Towson, MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Liceus	/	Dau 22	. Name and Addres		Towson	Funeral Ho 21204	
			23a. Part1. Enter the disease, or compli	cations that caused the death			<del></del>			Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	CAVEIN (NO 2	114	(clon	with m	e tasta	797	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	uence of):			, , , ,		out pu
	Examiner	_	Sequentially list conditions,	Dua to (or as a ec. seq	ere of					
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Das to for as a conseq	201100 017.					
ć.	cate be executed bhysician and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence	uence of):					
8760,	ate be nysicia he bur	dicai	d							
9	artifica ing ph e as th	Med	IF FEMALE:			1035,755				
.O. Box	The law requires that the death centificate be executed the hac been signed by the attending physician and hat e.g. should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	es that the igned by be detact	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	on in Part I.	23e. Did toba	cco use contribute to I	he cause of death?
ords	w require been sig should b	ted t						1 Tes	2 No 3 Pro	bably 4 Unknown
Vital Records,		Completed						24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
Vita	Physician: Tire this certificate ral director, pay	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death	1		
of	Phys r this ral dii	To To	1 ☐ Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time of	f 28c. Injury	at 28	e 5 A Residence 3d. Describe how	ce 6 Other (Speci injury occurred	fy)
ion	Attanding Ph er death. actor: After th by the funeral	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆 '	(? Yes 2 □ No			
Division	al or Attandii s after death. Il Diractor: A od in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office	28	Bf. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital or Attanwithin 24 hours after deatl To the Funaral Director: completely filled in by the	Medical C		ician: To the best of my knoner: On the basis of examina and manner stated.				d at the time, date	and place, and due t	o the cause(s)
)	To t withi To tl	×	29b. Signature and title of certifier	Toul		29c. License	13272		Date signed (Month,	
6	Y		30. Name and address of person who co	mpleted cause of death (Item	11.	Print) Tww	ion Md	, 212	roy	
	Sta Regista		31. Date filed (Month, Day, Year) DFC 2 0 2	32. Rehistrar's Signa	ture A	inte				

Amend item#30, perfyr, G850, 12/21/05 TI State of Maryland / Department of Health and Mental Hygiene () () 5 1 - Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** Deceas 18 5:54x 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death HAVRE DE GRACE HARFORD CO HARFORD MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2XXF Yrs. MARYLAND Director FEB 28 1947 58 219-42-9501 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinational be nutilised at 1 ☐ Yes 2 No Director MARYLAND HARFORD CO HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Mary, and 21215-0036 1 ☐ Yes 🏋 No Specify: þ Specify: 3 Widowed 4 □ Divorced BLACK natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within a Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "n any injury or other traumatic access Elementary/Secondary (0-12) College (1-4or 5+) K-MART HOUSEWIFE/STOCKER llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES S OUOMONY MARTHA MAE McGAW ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Spesutia Rd., Aberdeen, Md., 21001 Howard Jackson Jr./Brother Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-22-05 \* 4 ☐ Donation 5 ☐ Other (Specify) HAVRE DE GRACE, MD ST JAMES CEMETERY 21. Signature of Funeral Services 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P
321 S PHILADELPHIA BLVD,. ABERDEEN,MD 21001 cour complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1 Enter the disease shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC encep4 /Medical Due to (or as a consequence of): Examiner ardige arres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 70 24a. Was an autopsy performed? 1 Yes 2 of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No ၉ 1 Tes this filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After the standard of the Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 455222 aun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Gregory Little Harford Memorial Hospital Havre de Grace, MD 31. Date filed (Month, Day, Year)
DEC 2 1 2005 32. Registrar's Signature State mente Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** Howard Α. Aiken 14, 2005 December 0240 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□F Yrs. Director 89 July 19, 1916 Pennsylvania 221-03-5626 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Silver Spring Maryland Montgomery 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3426 Chiswick Court United States death or items Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status e filed within 72 hours after it Hygiene. other than "natural", or ite 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chemical proccess Technician Chemical Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth eny injury or other traumatic event <u>once.</u> Sara Elizabeth Sills Robert Aiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3426 Chiswick Court, Silver Spring, Maryland 20906 Hazel O. Aiken / Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition December 16, cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium 2005 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Obert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01356ossin 23a. Part 1. Enter the disease or Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Non Small Cell Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1X Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending investigation 1 🔀 Natural after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 24 hos To the Fune completely f Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D35635 December 14, 2005 erson who completed cause of death (Item 23a) (Type, Print) Name and address of 18111 Prince Philip Drive, #327, Olney, Maryland 20832 Joseph Kaplan, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 1 2005 Registrar

				For State Registrar	State of Ma	ryland / [		rtment tificate			and M		Reg. No.	Em UU	41089
		Physicia /Medic	_	1. Decedent's Name (First, Middle, Las Irene Araujo	t)							2. Date of De. Month DECEMP	Day SEP (	07 2005	
	1.	Examin		4a. Facility Name (If not institution, give						Location of	of Death			County of Dea	
		W e	×	Western Maryland F  5. Social Security Number 6. Se		enter (In yrs. last bir		Hager If Under		√ <b>N</b> If Under:	24 Hrs.	8. Date of Birt	th	shington	Thplace (State or Foreign
		Funeral Director	8	228-04-0297			Yrs.	Months		Hours	9.41m	(Manth Da	" Vaari	62 Not	a continui
- 1		ō.		Usual Residence of Decedent		10.01.7									
1		arylar show	7	10a. State 10b. County		10c. City, Tow									10d. Inside City Limits 1 X Yes 2 □ No
39		the M	Funeral Directo	Maryland Washingt	on	Hager	SLOW	/11 10f. Zip	Code				10a, Cit	izen of What C	<u> </u>
9		with with	i Dir	1500 Pennsylvania	Arraniia				742				-	ted Sta	-
-04		ms 2;	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	<u> </u>		spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am Bfack, Whi	erican Indian,
226-04-029	0	after or Its	/ Ful	1 ☐ Never Married 2X Married	1 ☐ Yes 2 🖾 N	0		Yes 2				rioari, etc./		Specify: Wh:	
3	3	within 72 hours after death with the Maryland ene. Than "natural", or tems 23a or 28a-f show he Mauscal Examinar chatte notiliad	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	160	Daned	ent's Usua	Ossuns	tion			16b K	ind of Business	
H (1)	Ç	in 72	ojete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of wor OO NOT us	done o	luring mos	t of worki	ng	100.10	ing of business	andastry
*	717	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)			Inv	alid					
TREAK	B	al Hyg	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,			
17	<u>X</u>	Ment Ment Marke	2		Not Know				/0:				Kno		7:- (2-4-)
0	Maryland 21215-0036	d 2 sh th and 7 Is rr traur		19a. Informant's Name/Relationship (19a. Hector E. Araujo /		1		•						or Town, State, hersbur	g, MD 20878
ARAUS	<u>စ</u> ်	Heall Heall tem 2		20a. Method of Disposition		20b. Place o					ecem			ocation - City o	
RA	ē	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Monte Crema	ome:	ry	nc.		.3 <b>,</b> 2	005	Beth	esda. N	Maryland
* :	Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Inportant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show in Items in Items		21. Signature of Funeral Service Licer	1 00.	01356	Ro- Ro-	Name and ckvil	Addres le, le,	s of Facilit Inc. Mary	yRobe 300 land	west M 20850-	Pump ontg 2805	hrey Fu omery A	ineral Home/ Avenue,
		Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	е.	not ent	er the mode	of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
		/Medical Examiner	liner	Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PS-22	a consequence		enth	7						18913
		icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	c. ue to (or as a	a con <table-cell> uence</table-cell>	of):								/07:3
	P.O. Box 68	Attending Physician: The law requires that the death certificate to death. If death. sector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the by.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the first term of the f	2 Fetal deat		]Ectopic pro ] Other (spe			- 3-2			23d. Date of de Month	alivery Day Year
-	rds, P	w requires that been signed is should be det	ed by P	Part II. Dther significant conditions of	ontributing to death bu	ut not resulting	in the u	nderlying ca	ause give	en in Part I	l. 		tobacco Yes 2		to the cause of death?  Probably 4 DUnknown
ı	Division of Vital Records,	ding Physician: The law re h. After this certificate has ber funeral director, page 2 sho	Completed									24a. Was auto perfo 1 ☐ Yes	psy ormed?	prior to death?	
:	/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	Harrist P				1011		e of Deati	n (Check only	one)		
;	<u></u>	Physic this c	5	1 X Yes 2 No 27. Manner of Death	Hospital: 1 X Inpatie		utpatier Time of			4 🗆 191		me 5 Resi		6 □Other (Sp	ecify)
	u C	ding h h. After funer	tion	1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day		Infury	M	8c. Injun Worl	k? Yes 2 📮	1	DROWNIN	•	•	004
	/ISI	Attend death actor: A	Certification:	3 Suicide 6 Could not b	e 28e. Place of Infi	ury - At home, f	NKNO farm, str				`	28f. Location (	Street ar	nd Number or F	Rural Route Number,
i	ă	s after	Cert	4 Homicide	building, etc	HUME						City or To 436 NS		MITAVE	MD 20877
		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier Certifying Pt (Check only 2 Medical Exer	nysician: To the best of	of my knowledg	ge, deat	h occurred vestigation,	at the tin	ne, date ar pinion, dea	nd place, ath occuri	and due to the red at the time,	cause(s date an	) and manner a d place, and du	as stated.
		To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	niner: On the basis of and manner sta					e number				ite signed (Mor	
		So A		250. Signature and title of certifier		Lorent, C	INT,			062	Q-Gir				
				30. Name and address of person who	completed cause of d	0005 eath (Item 23a)	69 6	2				nia Ave	אווף	-CI IISUK	207,2005
				PANLINE DALES	1.0		, , , , ,				-	21742	-1.40		
	No. of the last	St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 2 1	/	ar's Signature	K A								

				1 = For State Registrar		State o	f Maryla	nd / Dep <i>Ce</i>			lealth a	and M		Reg. No	0.05	41090
	2	Physicia	an	Decedent's Name (First, Mide BARBARA	lle, Last) ANN	BI	ну						2. Date of De	Day	Year	3: Time of Death U
		/Medic		4a. Facility Name (If not instituti					4b. City	, Town, c	r Location o	of Death	12		05 ounty of Death	
		Examili	er	Franklin Sa	uare	1100	DITAL	Center	P	ose	dale			I	SAltim	ore
		Funeral Director		5. Social Security Number 215–10–1894	6. Sex	M 20XF	7. Age (In yrs	92 Yrs.	Months	r 1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir Month Da 7-26-	rth	9. Birth	place (State or Foreign intry) Y.L.AND
		pug *		Usual Residence of Decedent  10a. Stale 10b. Count	v		10c. C	ity, Town or L	ocation							10d. Inside City Limits
		the Marylan 28e-f ehow nutified at	ctor	MD		IMORE				OLE 1	RIVER					1 ☐ Yes 2X No
		23a or 2	ai Dire	10e. Street and Number 1103 CHESTE	R ROA	AD			10f. Zi	p Code 21	220			10g. Citize	u.S.A	
	36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f ehow tha Madical Examiner must be multified at	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 X Widowed 4 Divorce	rried	2. Was Dece Armed Fo 1  Yes If Yes, Giv Year or D	2 <b>⊠</b> No ∕e	U.S. 13.		edent of Hearty Cub	dispanic Origan, Mexican  Specify:	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)		Race - Amer Black, White pecify: WH	, etc.
B	21215-0036	vithin 72 hou ne. han "natura n Madical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Educa est grade	ation completed) College (1	1-4or 5+)	(Give	DO NOT	ork done	during most d)	t of workii	ng		of Business/li	·
pa		77 75 2		12 17. Father's Name (First, Middle	, Last)				110.1	TT. IV TI		er's Name	(First, Middle	L		
Barbara	Maryland	Mental Mental arked c	To Be				ERP					ANNA				
13	Mar	d 2 sho th and t7 is mu traum		19a. Informant's Name/Relation HOWARD BIHY, J					-		ROAD		I Route Numb DDLE RI	-		p Code) 220
Bihy,	ore,	es 1 and 2 of Health of Item 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation				Place of Disp cemetery, cre	osition (Na	me of			ate		tion - City or 1	own, State
8	Baltimore,	Pag nent int: I		4 Donation 5 Other	Specify)		Ga				Cem 1				IMORE,	
	Bal	permit. F Departmitimportar eny injur		21. Signature of E	License	9					ACO A		H/ROSE ROS	EDALE		1 HOME: 21237
		Physician /Medical		23a. Part1. Effer the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complic st only one a.	Se Se	PSIS		nter the mo	de of dyi	ng, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
		Examiner			1	ACI	(or as a conse	oquence of):	illuri	0						
	760,	te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>{</b>		(or as a conse									
	687	2 2 9			d.											
	P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23	1 ☐ Live t	tcome of pregronth 2 Fet part at time of own	tal death 3	□Ectopic p □ Other (s		у			23	d. Date of deliv Month	rery Day Year
	rds, P.	quires that in signed by uld be deta	þ	Part II. Other significant condi	tions cont	ributing to d	eath but not re	esulting in the	underlying	cause gr	ven in Part I.				-	the cause of death?
	of Vital Records,	The law re cate has bee page 2 sho	Completed										24a. Was auto perfo 1 🗆 Yes	s an opsy ormed? 2 \( \sqrt{No} \)	24b. Were aut prior to c death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
	Vita	ician; certific rector,	Be	25. Was case referred to medic examiner?		ospital:				Ott			(Check only			
	on of	ding Phys n. After this funeral di	ion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pend	-	1 100	of Injury th, Day Year)	28b. Time ( Injury		28c. Inju Wo	4 🗀 INU	2	ne 5 Res 28d Describe			fy)
	Division	or Attendigited death	ertification:	3 Suicide 6 □ Coul	-	28e. Place build	of Injury - At ing, etc. (Spec	home, farm, s				-	28f. Location ( City or To	(Street and i	Number or Ru	al Route Number,
		Hospital 24 hours Funeral itely filled	edical Ce	29a. Certifier 1 Certify (Check only 2 Medic	ing Physi Il Examin	ician: To the	e best of my kr	nowledge, dea	th occurred	d at the ti	me, date an opinion, dea	id place, a	and due to the ed at the time,	cause(s) ar , date and p	nd manner as ace, and due	stated. to the cause(s)
		Fo the within :	Mec	29b. Signature and title of certification	·			······································			se number				signed (Month	
		- > - 0			Ly	X					0614			14	17/05	>
	1			30. Name and address Tress	m who one	9000	of death (Ite	em 23a) (Type (111) SQ1	vare	DRIL	ie Br	11+117	nore, M	D 21	337	
		Sta Registi		31. Date filed (Month, Day, Yea	1 20		odstřar's Sign	nature	freet	20			,			

			For Amend Item	23a per Marylar	850,12 Cei	ying tifica	5dhib e of L	ealth and Death	d Mer	ntal Hygie Reg	ene 2 0	105	***************************************	091
			Decedent's Name (First, Middle, Last,	)						Date of Death Month	Day	Year	3. Time	of Death
	Physicia /Medic		Nellie Irene	Burton					1 _	ecember			2:1	5 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	Town, or	Location of De	eath		4c. County	y of Death		
			Heartland of Adel			Ade1		M Clader O.A.	Jeo o		Princ		orge's	
	Funeral Director		5. Social Security Number 6. Se.	7. Age ( <i>In yr</i> s.	Yrs.	If Unde Months		If Under 24 H Hours M	lin. N	Date of Birth (Month, Day, Y	<b>19</b> 21	9. Births Cou	virgi	nia nia
			234-28-4387 Usual Residence of Decedent	*   04								Webe	,1161	
	yland		10a. State 10b. County		ty, Town or Lo					_			10d. Inside (	
	e Ma	ctor	Maryland   Prince G	eorge's		Gr	eenbe	elt 					1 □ Ye	s <u>X</u> □No
	h with th	al Director	10e. Street and Number 8013 Mandan Road	d T2			0770			100	g. Citizen of U . S		ntry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Itema 23s or 28s-f show important: if Item 27 is marked other than "natural, or Itema 23s or 28s-f show eny follury or other traumatic event, Ita Madical Exertiner resal be notified at once.	by Funerai I	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates:	1	Was Dece f Yes, spe l 🗌 Yes	cify Cubai	spanic Origin? n, Mexican, Pu Specify:	(Specify uerto Rica	Yes or No- an, etc.)	Bla	ce - Americ ck, White, fy: Whi		
Baltimore, Maryland 21215-0036	within 72 ho ane. than "natur he Medical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		16a. Deced (Give life. L Secre	kind of wi	al Occupa ork done d ise retired,	urina most of v	working		Sovern		dustry	
ე ე	filed Hygi ther ant, u		17. Father's Name (First, Middle, Last)		Decre	· car y		18. Mother's N	Name (F	irst, Middle, Ma				
an	lid be lental ked c	To Be	John Parsons					Minn	nie	Price	9			
Mary	d 2 shouth and M		19a. Informant's Name/Relationship (7) Charles R. Burton							oute Number, o Upper 1				772
ore,	les 1 an of Heali if Item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b.	Place of Dispo cemetery, crem	natory or	other place	Dec	Date 14	,2005 20	c. Location	- City or To	own, State	1 1
Ē	: Pag tment tant: tant:		4 ☐ Donation 5 ☐ Other (Specify)	l Ma	ryland					Funera:	Chelte			and —
Ba	permit Depar Impor eny in		21. Signature of Funeral Service Licens	Sterling Hor	4.35	Name a	01d A	s of Facility Alexand	lria	Ferry l	Road C	Clinto	on, MI	20735
			23a. Part1. Enter the disease, or composition of heart failure. List only of	ications that caused the dea ne cause on each line.	th. Do not ent	er the mo	de of dying	, such as card	diac or re	spiratory arres	t,		Approxima Interval Be Onset and	etween
3	Physician		Immediate Cause (Final disease or condition resulting in death)	Card	Ores	PIS	ata	ory		all	ere			
	/Medical Examiner		resulting in dealin)	Due to (or as a consec		/ tic (	ardi	ovascu1	lar I	Disease				
	*	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec				Juscal		LICCIDE				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	End St	age Rer	nal I	isea	se						
ó	exec en an rial-tr	Еха	resulting in death) Last	Due to (or as a consec	quence of):									
8760,	cate be executed physicien and the burial-transit	dicai	(	d										
39 )	artifica ing ph e as ti	Med	IF FEMALE:											
Box	that the death certifi ed by the attending I detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feti 4 ☐ Pregnant at time of a 9 ☐ Unknown	aldeath 3□	Ectopic p Other (s						ate of delive onth	ery Day	Year
P.O.	at the	Phy	9 Unknown							00 0000				( ) ( )
rds,	w requires that s been signed b should be det	ed by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ui	nderlying	cause give	in in Part I.		23e. Did toba 1 ☐ Yes		3 ☐ Prof	7	Unknown
000	aw re	Completed								24a. Was an autopsy	24b.	Were auto	opsy finding empletion of	s available
Ĕ	The I	E							-	performe	ed?	death?		Cause of
<u> </u>	ortifical ctor.	Be	25. Was case referred to medical examiner?		727.5			26. Place of I	Death (C	heck only one				
<u>&gt;</u>	hyeld this or al dire	은	1 □ Yes 2 No		] ER/Outpatien			AUT Nursin		5 🗌 Residen			fy)	
0	ding P th. : After s funera	tion:	27. Manner of Death  10 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury Work 1 🔲 ۱	at ? ∕es 2 □ No	28d	. Describe how	injury occu	rred		
Division of Vital Records,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, facto	ry, office		28f.	Location (Stre City or Town,	et and Num. State)	ber or Run	al Route Nu	mber,
	Mospita 24 hours Funera etely fille	edical C	253 Certifier 1 Certifying Phy (Check only one)	sicism To the best of my kniner: On the basis of examin and manner stated.	cwledge deat ation and/or in	occurra vestigatio	at the tin n, in my op	e, date and pli pinion, death or	ace and courred	due to the eau at the time, dat	es(e) and m e and place,	annor as s and due t	taled. o the cause	o(s)
	To the within To the complex	Me	29b. Signature and title of gertifier			29	c. License			290	t. Date signe	ed (Month,	Day, Year)	1
ey.			) Hhu	ma MD.			6	099	9		12	181	05	
	(6)		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type,	Print)					1	1		
_	11		Aruna Paspula, I		- 2	et, N	W Sui	te 415	, Wa	shingto	n, DC	2001	0	
	Sta Registi		31. Date filed (Ment) Day, Year)	32. Registrar's Sign	ature	j.								

1 - For State Registra 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Sinai 5. Social Security Number **Funeral** 251-80-0760 Director Usual Residence of Decedent 10a. State

Director

Anna

Md.

10e. Street and Number

Hospital

10b. County

2409 W. Coldspring Lane

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3 → Widowed 4 Divorced

1 □ M 2 □ F

NA

or 28a-f show f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28a-1 show other traumatic event. Its Medical Examinst must be rediffed at 1 and 2 should be filed withi Health and Mental Hygiene. ō

Known as Anna Bonaparte imore, Maryland 21215-0036 Completed by Funeral Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Domestie 17. Father's Name (First, Middle, Last) Be Rickenbaker Annie Randolph 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2409 W. Coldspring Lane, Baltimore, Md. Daughter Bernice Bruce 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12-27-05 Mt. Zion Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bepsis Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) infarction Examiner Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed has 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 4 Homicide 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title-of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Mejer 32 Registrar's Signature 31. Date filed (Month, Day, Year) Essele ! State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Reg. No. 2. Date of Death 3. Time of Death Month Day December 13 2005 223 PM 4b. City, Town, or Location of Death 4c. County of Death Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 9-14-12 S.C. 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Unkn 20c. Location - City or Town, State Lansdowne, Md. Baltimore, Md. 21202 1101 E. North Ave.

Approximate Interval Between Onset and Death -weeks

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death 4 Donknown 1 Yes 2 No 3 Probably

24b. Were autopsy findings available prior to completion of death? 24a. Was an autopsy 2010 2 100 1 Yes

6 ☐Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

December 13, 2005

2005 10 AR.

Certificate of Death

Days

21215

1 ☐ Yes 2 No Specify:

Baltimore

10f, Zip Code

Hours

Bonaparte

of Baltimore

12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:

93

7. Age (In yrs. last birthday)

10c. City, Town or Location

		1	For State	State of Marylan	d / Depa		lealth and N	lental Hygie	ene 2005	1003			
_			Registrar  1. Decedent's Name (First, Middle, Last)			incate or i	Bouiri	2. Date of Death	No: U U U	3. Time of Death			
Phy:	sicia			ECKER				Month DECEMBER	19, 2005	11:55A. <sup>M</sup>			
	edica		4a. Facility Name (If not institution, give st			4h City Town or	r Location of Death	DECEMBER	4c. County of Death	<del></del>			
Exa	mine	er							FREDERICK				
			307 BRUNSWICK STRE  5. Social Security Number 6. Sex	7. Age (In yrs. /	ast birthdav)	BRUNSWIC	If Under 24 Hrs.	S. 8 Date of Birth 9 Birtholace /State or Foreign					
Fune Direct				M 2□F 75	Yrs.	Months Days	Hours Min.	JUL 6, 1	ear) Cou	ntry) INIA			
	LUI	L	Usual Residence of Decedent				l	301 0, 1	750 VING	INIA			
yland	4		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. tnside City Limits			
Mar Mar		호	MARYLAND FREDERICK	В	RUNSWI	CK				1  Yes 2 No			
h the		Directo	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?			
h wit		<u>_</u>	307 BRUNSWICK STREE	T		21716	5	-	U.S.A.				
deat		-		2. Was Decedent Ever in U. Armed Forces?	S. 13. \	Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto		14. Race - Ameri Black, White,				
after or		교	1 ☐ Never Married 2 🛣 Married	1 ☐XYes 2 ☐ No 11 Yes, Give		Yes 2∭ No				WHITE			
1215-UU36 within 72 hours after death with the Maryland one. than "natural, or items 23a or 28a-f show a Maritan Earth for marting the profitien of an expense.		à	3 Widowed 4 Divorced	Year or Dates: 1952-	1954								
72 h		Completed	15. Decedent's Educi (Specify only highest grade	ation com <i>pleted)</i>	16a. Deced (Give	lent's Usual Occup kind of work done	ation during most of work d)	ina	b. Kind of Business/Ir	,			
L util of the		ᇎ	Elementary/Secondary (0-12)	College (1-4or 5+)					U. S. FEDE				
filed v			a 7 Tabada Nama (Fine Adiddle Local)	2	FKINI	ING SPECA		e (First, Middle, Ma	GOVERNMENT				
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene. T's transkad other than "natural", or remarked other than "natural", or		m	17. Father's Name (First, Middle, Last) LESTER JACOBE BEC	KER				LIZABETH	WALKER				
aryla should and Men		၉			100 11 333					- 0-4-1			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If them 27 is marked other than "natural", or Items 23a or 28a-1 show any lainty or other than mails event.		1	19a. Informant's Name/Relationship (Typ			•			ity or Town, State, Zij				
e, N 1 and 1		-	ELEANOR M. BECKER /			Sition (Name of			K , MARYLAN  c. Location - City or To				
Pages nent of the	5	1	1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, cren	natory or other plac	(e)		_				
TIP TIME TIME TENT	, in		4 □ Donation 5 □ Other (Specify)			NATIONAL			ANTICO, VI				
Baltimore, permit. Pages 1 ar Department of Hea Important: if item	DC		21. Signature of Funeral Service License	la					VANS FUNER				
40.5		-		7					, MARYLAND	20715 Approximate			
			23a. Part1. Enter the disease, or complic shock, or heert failure. List only one	ations that caused the death cause on each line.	1. Do not ent	er the mode or dyin	AA	or respiratory arrest	'	Interval Between Onset and Death			
Physici	_	1	tmmediate Cause (Final disease or condition resulting in death)  a										
/Medio	_												
		_	Sequentially liet conditions, b	Due to (or as a consequ	iance of):		· ·						
V 2 3	į	ine	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	<b>16</b> 11 <b>06</b> 01 <i>1</i> .								
60, Company of the second of t	1	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):								
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687 tifficate ig phys			d.					. 1					
Box 68 leath certificate attending phy	D D	Physician/Med	IF FEMALE: 23	c. If yes, outcome of pregna	ncy				23d. Date of deliv	erv			
BOX eath cent attending	5	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal		Ectopic pregnancy Other (specify)	/		Month	Day Year			
hat the did by the	De Li	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		, . , , ,							
of Vital Records, P.O. Box 68 Physician: The law requires that the death certifica this certificate has been signed by the attending phy	Gela	4	Part II. Dther significant conditions conf	ributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	the cause of death?			
ds urres sign	5	d by						1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown			
Division of Vital Records, i or Attending Physician: The law requires t after death.  Director: After this certificate has been signer in the trick of discount or and 2 should be a tricked of discount or and 2 should be a	nous	lete						24a. Was an	24b. Were auto	opsy findings available			
The lay	96	Completed						autopsy performe	d? prior to co	ompletion of cause of			
Vital F vician: Th certificate	i.	ပိ	25. Was case referred to medical		···		26 Place of Dea	1 Yes 2U	No 1 ☐ Yes	2 No			
Sicia sicia cent	Lect	00	examiner?	ospitat:	EB/Outpatier	t 3C DOA Oth	oc	1/	ce 6 □Other (Speci	60			
P y Signatura	eral o	2	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at	28d. Describe how		•••			
O D ding	Uni.	흕	1 Tatural 5 Pending 2 Accident investigation	(Month, Day Year)	tnįury	M 1 🗆	rk? Yes 2 ☐ No						
VISION Attending r death. ector: After	ž	Hca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, str	eet, factory, office			et and Number or Rur	al Route Number,			
Div A i affer i Direction	0 0	Certification:	4  Homicide	building, etc. (Specify	V)			City or Town,	Siate)	regrando de esta e e actual de esta			
Division of Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	y Tille		29a. Certifier 1 Certifying Phys	cian: To the best of my kno	wledge, deat	occurred at the tir	me, date and place	and due to the cau	se(s) and manner as	stated.			
the Ho hin 24 h	996	edicai	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my d	opinion, death occur	red at the time, date	and place, and due t	o the cause(s)			
To the	Ē	ž	29b. Signature and title of certifier			29c. Licens			. Date signed (Month,				
	111		Smil	m 1	わり	DS	58391		12-19-	05			
Int	7		30. Name and address of person who con	npleted cause of death (Item	1 23a) (Type,	Print)	-	^	0 0 4	A = 1			
10		_0	SAJJAN HZ	2, mo.	01 -	witte	use A	M FA	derid 1	05 1D2170			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	20	20.	/		7			
Reg	gistr	ar	DEC 2 1 2005	La proportion Silver	A STATE OF THE PARTY OF THE PAR								

Physician /Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4d. County of Death	3. Time of Death  2: 15  M  (State or Foreign
Funeral Director  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4d. County of D	
Funeral Director  Usual Residence of Decedent  5. Social Security Number 1 Mm 2 F 7. Age (In res. last birthday) 1 I Under 1 Year 1 I Under 24 Hrs. Months Days Hours Min. 9. Birthplace Gountry)  Usual Residence of Decedent	(State or Foreign
Director Usual Residence of Decedent  Director  Usual Residence of Decedent	yland .
Z TA S NIN	Inside City Limits 1 XYes 2 ☐ No
Bottinge  10e. Street and Number  10f. Zip Code  10g. Citizen of What Country	
= 36 E. 264h Street 21218 USA	1-41-
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  Never Married 2 Married  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Black, White, etc.  15 Yes, 2 No Specify:  Specify:	
Specify:  Specif	25100
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industrial (Control of the kind of work done during most of working life. DO NOT use retired)  Administrator Insurance	,
Administrator Insurance    The control of the contr	
Elementary/Secondary (0-12)  College (1-4or 5+)  Administrator  Insurance  To go of the property of the proper	ONL
19a. Informant's Name/Relationship (Typerficuld) Exempted Address (Street and Number or Rural Robe Number, City or Town, State, Zip Co  Dwight A. Schwartz 46 E. 26 45. Balto MD 2121	de)
Duight A. Schwartz  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Creenmount Crematory 12/23/05	State
20a. Method of Disposition    Date	vias
THE W. THE THE BURNING BOTH DO	212
shock, or heart failure. List only one cause on each line.	proximate erval Between nset and Death
Immediate Cause (Final disease or condition resulting in death)    Medical Examiner   Due to (or as a consequence of):	Unknom
Sequentially list conditions. If any, leading to immediate  b. Due to (o. as a consequence of):	years
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Cause (Disease or injury that initiated events resulting in death) Last  Due to (of as a consequence of):  d.  Due to (of as a consequence of):  d.	
S of the state of	
1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?  4 Pregnant at time of death 5 Other (specify)	y Year
9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the contributions c	ause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the conditions of t	y 4 Unknown
24a Was an 24h Wara autonsv	findings available etion of cause of
1   Yes 2   No 1	₹Ro
25. Was case referred to medical examiner?  1   Yes   2   No   No   No   No   No   No   No	
27. Manner of Death   Natural   Solicide   Accident   Solicide   Solicide   Solicide   Solicide   Solicide   Solicide   Solicide   Solicide   Solicide   S	
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Ro	oute Number,
building, etc. (Specify)  City or Town, State)	
building, etc. (Specify)  City or Town, State)  City or Town, State)  City or Town, State)  29a. Certifier (Check only)  29a. Certifier (Check only)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state	d.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day	e cause(s)
Thomps Thompson, MD, FACP D 57088 DECEMBER 21	cause(s)
	cause(s)

State of Maryland / Department of Health and Mental Hygiene

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Bartimore, Maryland 21213-0030		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	[	
Depertment of Health and Mental Hygiene.	Fu	_
important: if item 27 is marked other then "natural", or items 23s or 28s-f ehow	ın	
any injury or other traumatic event, the Madical Examiners, ust be notified at	er ct	
	a	

			Ragistrar		Ce	rtificate	OT L	Jeath			Rag. No."	000	41090
			1. Decedent's Name (First, Middle, Las	it)					1	2. Date of De Month	ath Day	V	3. Time of Death
	Physicia		Mohamed	A		I	Bar	re		Decemb			01:59 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of		00000		County of Dea	
	LAdillii	C1	Sinai Hospital			Balti							
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birthday)	ay) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,					th y, Year)	9. Bir	thplace (State or Foreign buntry)
	Director		364-27-4579	M 2UF	26 Yrs.					08	08	79	Somalie
	p ,		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	- Cation							10d. Inside City Limits
	aryla shov	Ļ											1 Tes 2/10/No
	Ba-1	ct	MD Balt	imore	Coci	ceysv:		e					
	or 2	Director	10e. Street and Number			10f. Zip 0	Code				10g. Citiz	en of What Co	ountry?
	238 238	<u>a</u>	818 Cinnamon R	idge E		_	210					Somali	
	r de	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		Was Decede If Yes, specif	ent of Hi fy Cuba	ispanic Origi n, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>	
2	or if	Y.	Never Married 2 Married	1 ☐ Yes X☐ N If Yes, Give	10	1 ☐ Yes 2	🖄 No	Specify:				Specify: _	lack
	be filed within 72 hours after death with the Manyland tal tygiene.  ad other then "natural; or items 23a or 28a-f show event, the Madical Examinan; and the notilised at	d by	3 Widowed 4 Divorced	Year or Dates:	10-0	d - Al- Maria	0				105 16		
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V	withir	립	Elementary/Secondary (0-12) 12th grade	College (1-4or 5 2yrs+	)+)	Гахі					Τá	axi Co	mpanv
ב ב	Hygint ther		17. Father's Name (First, Middle, Last)		··				's Name (	First, Middle,			L 2
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5	should be filed within and Mental Hygiene.  marked other then umatic event, it e.m.	ဥ	19a. Informant's Name/Relationship (	Tvoe. Print)	19b. Maili	na Address /	(Street a				er. City or	Town, State.	Zip Code) 21030
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נב	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition		20b. Place of Disponentery, cre				Da	-		ation - City or	
Daillinor	ages int of t: If if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removal from State	Kina Mei				1 2 / 1	0/200	5 D.	n da 11	atour
	artme ortan ortan injury		21. Signatura Funeral Service Licer							9/200	) No	indali	SCOWIL
D D	permit. Pages Depertment of h Important: If ite any injury or of		MANANA	C	ANIX ME	2. Name and 3 C C M	F/H	West	t vo.	Balti	more	δM .c	21215
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			s ock, or heart failure. List only it mediate Cause (Final										Interval Between Onset and Death
	Physician /Medical		isea e or condition risk ting in death)	a HULTIP		SHOT		WOV	WD (				
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00	ficate phy is the	n/Medical		. 4.				_					
Š		Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	76					2	3d. Date of de	livery
Ď	death a atte		in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify)						Month	Day Year
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r	s that	by Physicia	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	ınderlying ca	use give	en in Part I.		23e. Did t	obacco us	se contribute to	the cause of death?
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ecoras	iaw reces bee	Completed								24a. Was		24b. Were a	utopsy findings available
Ē	The la	E									rmed?	death?	completion of cause of
VII A	ificat or. pa	ပိ	25. Was case referred to medical					26 Place	of Death	(Check only o	2 No	1∕☐Yes	2 🗆 No
	Physician: rthis certific ral director,	0 8	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 XER/Outpatie	nt 3 DOA	Othe	25				□Other (Spe	roifu)
0	a Physical controls	I	27. Manner of Death	28a. Date of Injur	ry 28b. Time o		Bc. Injury	/ at		3d. Describe			chy,
JIVISION	Attending r death. ector: After by the fune	i i	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Da)	1100	AM	Work	k? Yes 2.DA∜N	lo S	SVB JE C	TV	2 2AU	HOT
	Attendi r death. ector: A by the fu	HC	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	e. Place of Injury - At home, farm, street, factory, office				28	28f. Location (Street and Number or Rural Route Number,			
5	at or atte	Certification;	4-2 Homicide determined	c. (Specify)	ES 10 ENCE 400 E BELY EDS				DERE A	E, BALTITORE.			
	hours nera y fille			ysician: To the best	of my knowledge, dea	th occurred a	t the tim	ne, date and	place, ar	nd due to the	cause(s)	and manner a	s stated.
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the atter completely filled in by the tuneral director, page 2 should be detached for	edical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination and/or in ated.	nvestigation, i	in my of	pinion, death	n occurred	d at the time,	date and	place, and du	to the cause(s)
	To 11 withii To 11 comp	ž	29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)				
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		100											A second

State Registrar RNAIO, MD 111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

BNA 31. Date filed (Month, Day, Year)
DEC 2 1 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** DECEMBER 17, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner HOSPITA NOR THIWEST RANDAILSTENA BALTINE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months XXM 2 F Director 65 220-92-6633 APRIL 30 1940 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits wods the Medical Examiner must be notified at 1 Yes 2XXNo Director BALTIMORE or 28a-f t BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Itema 23a 21208 U.S.A. 4728 MARY KNOLL RD. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 本述No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ŏ 1 ☐ Yes 2 X No Specify. Specify: BLACK ģ 3 X Widowed 4 ☐ Divorced "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) ELECTRICIAN ARMCO STEEL 8th grade other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ELIZABETH STERN ဂ္ DANNY BROWN SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 la 4728 Mary Knoll Rd., Baltimore, Md., 21208 Marla Valentine/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō <u>-</u> 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of important: If eny injury or once. 05 KING MEMORIAL PARK Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Monage 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? AABE TUS 2010 1 🗌 Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 7 NO Certification: To 1 Impatient 2 ER/Outpatient 3□ DOA 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 - Homicide Hospital within 24 hours a 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and t e of certifile 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records, P.O.

ORIGINAL

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31. Date filed (Month, Day, Year)

CONTRNAN

32.

Registrar's Signature

# ■ Baltimore. Maryland 21215-0036

Division of Vital Becords P.O. Box 68760.

		1 - For State Registrar			artment of rtificate of	Health and M Death	Re	9. No. () () [	41097
Physici		Decedent's Name (First, Middle, La     ETHEL S	st) IMON BYRD				2. Date of Death Month December	Day Yea	
/Medio	- 4	4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of Death		eath	
4		MARINER HEALTH 5. Social Security Number 6. S		SVILLE In yrs. last birthday)					TIMORE  Birthplace (State or Foreign
Funeral Director			□ M 2 <b>X</b> XF	81 Yrs.	Months Days		8. Date of Birth (Month, Day, June 10	Year)	Country) OUISIANNA
hours after death with the Maryland tural', or Items 23a or 28a-f show at Examinar must be notified at	7	10a. State 10b. County	1	Oc. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 No
the Maryla 28a-f shorn	Director	MARYLAND N/A  10e. Street and Number		BALT	IMORE 10f. Zip Code		10	Country?	
23a or		1190 W NORTHERN P	KWY APT 81	8	2	1210		U.S.A.	
r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of II Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
ours after death v al', or Items 23e Examiner must	by	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 22 1 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗶 No	Specify:		Specify:	BLACK
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permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Tice	rsge			ress of Facility COI			
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be executed ician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c <del>-</del>	consequence of):	c Cer	zheinen	'i type	Demati	2 y v
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnar □ Other (specify)	псу		23d. Date of o	delivery Day Year
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/			100	Mysici	m 1>	297	69	12/	19/05
108		30. Name and address of person who	completed cause of dea	ath (Item (23a) (Type	Print)	5 (6 N.	Ro 11. 10	28 6	1N. 3172
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			For State Registrar		State of Ma	ıryland		artmer <i>rtificat</i>			Mental Hy	/giene	005	4109	98
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P.O. Box	at the death certific by the attending pi tached for use as t	Physician/M	1F FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ No 9 □ Unknown	nths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal d	eath 3[	⊒Ectopic p ⊒ Other (s				2	23d. Date of delivery Month Day Year		9ar
	The law requires that the ate has been signed by the bage 2 should be detache	ğ	Part II. Other significar	nt conditions co	ntributing to death bu	ut not result	ing in the u	inderlying	cause give	en in Part I.			se contribute	to the cause of de	nknown
I Records,		Completed									per	s an opsy formed? 2 No	24b. Were prior death		vailable use of
/ita	Attending Physician: r death. ector: After this certific by the funeral director.	Be	25. Was case reterred examiner?	-	Hospital: /				0#5	26. Place of De	ath (Check only	one)			
<b>o</b>	Physi this o	5	1 Yes 2 No 27. Manner of Death		Hospital: 1 Inpatie		NOutpatie			4   Nursing I	dome 5 ☐ Res			pecify)	
Ou	ding h. h. After funer	tlon	_ /	Pending investigation	(Month, Da)	Year)	Injury	м	28c. Injury Work	Yes 2 □ No	20d. Describe	s now injury	Cocumen		
Division of Vital	je de je e	Certification:		Could not be determined	28e. Place of Injubulding, etc	ury - At hom c. (Specify)	e, farm, st	reet, factor	ry, office			(Street and own, State)		Rural Route Numb	997,
_	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the completely filled in the formal or the filled in the formal or the filled in th	Medical Co			vsician: To the best of iner: On the basis of and manner sta	examinatio									
	Veith:	Σ	29b. Signature and title	of certifier			mx	29	c. License	number				onth, Day, Year)	
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1	2		30. Name and address		301 00	spita	1 2	rive		en Bus	mie	MOS	210	61	
78	Sta		31. Date filed (Month, L		32. Registra	_	re	Angel	1				,		
. 6	Regist	ar	1	DEC 2 1	2005	and I	15°								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician December 18, 2005 8:00 A.M Joan Henrion Bailey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace | Country) | November 1, 1933 | Canada 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 72 Yrs. Director 552-48-4443 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or then "natural", or itame 23a or 28a-f ehow the Modical Examinar must be notified at 1 Ves 2 No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20016 3201 Wisconsin Avenue, N.W., Apt. 206 Canada Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ğ Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) ie marked other then College (1-4or 5+) 5+ Journalist Newspaper es 1 and 2 should be filed of Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other? or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Henrion Ethel Power ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Bailey /Son 17535 32nd Avenue, N.E., Seattle, Washington 98155 20b. Place of Disposition (Name of cemetery, crematory or other place) December 21, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: if ite
eny injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2005 Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licenses 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilateral Pneumonia /Medical Due to (or as a consequence of): Examiner Multiple Infected Decubitus Ulcers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-transit Possible Sepsis Due to (or as a consequence of): Box 68760. physician Cystitis Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached ል cate has been signed , paga 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. δ History of Hypertension, History of Stoke, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Diabetes Mellitus Type-II 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 2 🔯 No 1 🗌 Yes of Vital Physicien: After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident aftar death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or /
 24 hours after
 Funeral Dire 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63334 December 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Haval M. Saadlla, M.D. 31. Date filed (Month, Day, Year)
DEC 2 1 2005 32. Registrar's Signature Registrar

			For State Registrar		eartment of Health and ertificate of Death	Mental Hygier	711115 1.1100		
П	Physici		Decedent's Name (First, Middle, I  REGINALD	R R	BATTISTA	2. Date of Death Month	Day Year 3. Time of Death		
	/Medic Examir		4a. Facility Name (If not institution, g	rive street and number)	4b. City, Town, or Location of Dea		4c. County of Death		
	Current		LEVINDALE HEBRE  5. Social Security Number 6	W HOME  7. Age (In yrs. last birthda)	BALTIMORE  () If Under 1 Year   If Under 24 Hr	s. 8. Date of Birth	N/A  9. Birthplace (State or Foreign		
	Funeral Director		089-22-9864	1 M 2 F 75 Yrs.	Months Days Hours Mir	8. Date of Birth (Month, Day, Yes 06/06/193	9. Birthplace (State or Foreign Country)  N.Y.		
	yland low		Usual Residence of Decedent  10a. State 10b. County	10c, City, Town or I	ocation	<u> </u>	10d. Inside City Limits		
	Ba-f sh	ctor		N/A BALTIMOR	RE		1√ Yes 2 □ No		
	with the Se or 2.	Funeral Director	10e. Street and Number	HTS AVENUE APT. #204	10f. Zip Code 21208		Citizen of What Country?		
	death	nera	11. Marital Status		. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		U.S.A.  14. Race - American Indian,		
36	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 No KOREAN	1 ☐ Yes 2 No Specify:	no nican, etc.)	Black, White, etc.  Specify: WHITE		
21215-0036	within 72 hours after death with the Maryland ane. then 'netural', or Items 23e or 28a-f show the Madical Examinar must be notified at	ted t	15. Decedent's (Specify only highest t	Education 16a. Dec	edent's Usual Occupation e kind of work done during most of w	16b.	Kind of Business/Industry		
121	within i	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	В	UGLE LINEN UPPLY CO.		
	e filed with I Hygiene. other ther	Be Co	17. Father's Name (First, Middle, La	st) MANA		ıme (First, Middle, Maid			
Maryland	should be ind Mental i marked o	ToB	SAM		TTISTA VIRG		SASS0		
Mar	C/ 60 00		PATRICE P. BAT		ling Address <i>(Street and Number or F</i>   PARK HFIGHTS AV		y or Town, State, Zip Code) BALTIMORE, MD 21208		
ore,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Disp			Location - City or Town, State		
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	city) HAR SINA		20/2005 OW:	INGS MILLS, MD		
Bal	permit. Pag Department Importent: I eny injury o	į.	21. Signatur of Funeral Service Lic	Buga 8	ROAD - PIK	& BROS., INC. ESVILLE, MD 21208			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplications that caused the death. Do not en ity one cause on each line.	nter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death		
1	Pnysician /Medical		disease or condition resulting in death)	aAmyotrophic L Dutto (or as a consequence of):	ATENAL SCENO	sis-uke L	yndane years		
0	Examiner	L.	Sequentially list conditions,	b. Due to (or se a noneequance of):					
	outed Id ansit	Examiner	any, leading to infradiate cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
8760,	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a consequence of):					
687	ificate I g physi as the t	edical		d					
Вох	death certifica attending ph d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of delivery  Month Day Year		
O.	the dea y the all ched fo	Physician/Med	1 Yes 2 No	4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month Day 16a		
Δ.	The faw requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	by Pr		s contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?		
Records,	w require been si should I		Sepsis			1 🗆 Yes			
Rec	he faw e has l age 2 s	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?		
Vital		BeC	25. Was case referred to medical examiner?			1 ☐ Yes 2 <b>Y</b> outh (Check only one)	No 1 □ Yes 200 To		
of	<b>사</b> 등 등	. To	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatie		Home 5 Residence			
ion	Attending I r death. ector: After by the funer	atlor	1 Natural 5 Pending investigat	(Month, Day Year) Injury	of 28c. Injury at Work?  M 1 Yes 2 No				
Division	or Atter after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)		
	To the Hospitel or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical Ex	Physician: To the best of my knowledge, dea aminer: On the basis of my knowledge, dea	th occurred at the time, date and place	e, and due to the cause	(s) and manner as stated.		
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stayed.	29c. License number	29d. [	Date signed (Month, Day, Year)		
	, , , ,	}_	- Mily M	ull	123767	PE	Date signed (Month, Day, Year)  Ecomber 19, 2005  140. Pd. 21215		
6	2		30. Name and address of person wh	o completed cause of death (Item 23a) (Type	Print) Rolladero In	Le la	HA PH. 7125		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	and a second	- De	المارية المارية		
	Regist	rar	DEC 2 2	2005					

Reginald latista

**Physician** /Medical

Examiner

Director

To Be Completed by Funeral

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28a-f show eny injury or other traumatic event, Ite Medical Exercises must be retified at

Please					All Copies A		
For State Registrar	State of Ma	- ,		of Health and of Death	Mental Hygie	ene 005	41101
Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
Florence		Cro	martie		Month December	18 2005	A44 A57 A L
a. Facility Name (If not institution, giv	e street and number)		4b. City, To	own, or Location of Dea		4c. County of Dea	ath
Simai Hospin	41 of Ba	Itimore		Baltim	ore	NA	
Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birthday	) If Under 1 Months I	Year If Under 24 Hr	s. 8. Date of Birth	(ear) 9. Bi	rthplace (State or Foreign
19-10-3//3	□M 2√F	86 Yrs.	111011110	34,0	8-21-		νa.
sual Residence of Decedent la. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limit
Md. NA		Baltim					1 X Yes 2 N
		Darcin			10	0161	
e, Street and Number			10f. Zip C	ode	100	g. Citizen of What C	ountry?
1316 N. Potomac				21213		USA	
. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13,	Was Deceder If Yes, specify	nt of Hispanic Origin? ( Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 25 1 If Yes, Give Year or Dates:	VO	1 ☐ Yes 🍇	☐ No Specify:		Specify:	Black
15. Decedent's E	1		edent's Usual (	Occupation	142	3b. Kind of Business	
(Specify only highest gra	ade completed)	(Give	e <i>kind</i> of work DO NOT use	done during most of w		Jo. INITIO OF EUSTINESS	usuy
Elementary/Secondary (0-12)	College (1-4or 5	5+)	sembly	,	1	Western E	lectric
12th grade . Father's Name (First, Middle, Last	2 yrs.	AS	Semory		ame (First, Middle, Ma		Tectife
Willie		Walker		Julia	a	Broad	nax
1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Licential Part 1. Enter the disease, or companies of the sease or condition sulting in death)	plications that caused one cause on each lii  Due to (or as	Arbutu	March	Pk. 12 Address of Facility F.H. East of dying, such as cardi	Balt 1101 E.	Arbutus, imore, Md North Av	. 21202
any, leading to immediate luse. Enter Underlying ause (Disease or injury	Due to (or as	a consequence or;:/		,			
nat initiated events esulting in death) Last	c. Due to (or as	a consequence of):			-		
· ·							
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic preg			23d. Date of de Month	elivery Day Year
art II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cau	se given in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
Niele	tes Melli	tus	-		1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknow
					24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings availab completion of cause of
					1 ☐ Yes 2	No 1 ☐ Ye	s 2 No
5. Was case referred to medical examiner?	Hancital:				eath (Check only one)	Y	
1 No 2 No	Hospital:			<u> </u>	Home 5 Residen		ecify)
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) 28b. Time Injury	of 280	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	rinjury occurred	
3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, o	office	28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,

**Physician** /Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the tunneral director, page 2 should be detached for use as the buriar-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D59062

29d. Date signed (Month, Day, Year) 18 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore MD 21215

Chad J. Hansen
31. Date filed (Month, Day, Year)
UEC 2 1 20 32. Registar's Signature 2401

AEM 05-08388 Arthur Cole

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hur	Cole	4	_ State	artment of Health and Ment rtificate of Death	2003	5 41102
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No.	3. Time of Death
	Physicia	an	A. House C. La	M	onth Day Ye cember 12. 200	ear
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of [	
4	LXaiiiii		501 East Preston Street Apt. 705	Baltimore City	n/a	
	Funeral Director		5. Social Security Number 6. Sex 2 F 7. Age (In yrs. last birthday, 2 F 48 Yrs.	If Under 1 Year   If Under 24 Hrs. 8, Da		Birthplace (State or Foreign Country)
		t	Usual Residence of Decedent	00/	1011,1137	
	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 Pres 2 □ No
	Ba-f-e	5	MD N/A Balti			
	vith th	Pre	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	t Country?
	eath v	erai	501 E. Preston St. Apt. 705  11. Marital Status  12. Was Decedent Ever in U.S. 13.		es or No-	American Indian,
<b>'</b> 0	fter d	by Funeral Director	1 Never Married 2 Married 1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican		White, etc.
5-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow iteal Examinar must be notified at		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	Black
	72 ho	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working	16b. Kind of Busin	ess/Industry
2121	within ene. than "	dm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) road Track Mainten	Pail	-200
N	filed Hygie Sther	ပိ	17. Father's Name (First, Middle, Last)		t, Middle, Maiden Sumame)	000
Maryland	2 should be filed within 72 hours after death with the Marylan and Meantal Hygiene and Meantal Hygiene is marked other than "natural", or Items 23a or 28a-f show aumstic event, the Mealon Examinar must be notified at	To Be	Arthur Francis Cole	Harriet	H Wells Co.	bert
ary	and M e mer			ing Address (Street and Number or Rural Rou		
	es 1 and 2 of Health of fitem 27 b		Carol Cole/Sister 93	Z Mc Donogh St	t. Baltimore	50212 CM
ore	of He			matory or other place)	20c. Location - Cit	
Baltimore,			4 □Donation 5 □ Other (Specify)   Bow Vie	w Crematory 12/21/		one, MD
Bai	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	2. Name and Address of Pacifity Funen Her, P. Close Funen 5126 Belown Roa	al Service, F D. Baltimoru i	1.A. 4D 21206-5105
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Fulmonary thu	romboemboli		Onset and Death
1	/Medical Examiner		Due to (or as a consequence of):	dhambari		
		er	Sequentially list conditions, if any, leading to immediate  b. <u>Deep Venous</u> Due to (or as a consequence of):	Tructions		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
oʻ	be executed ician and burial-transit	Ехв	resulting in death) Last Due to (or as a consequence of):			
8760,	cate be exphysician the buria	dicai	d			
9	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	Amp	23d. Date o	f delivery
Вох	d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 \[ \subsection \text{Ves} \ 2 \subsection \text{No} \]  4 \[ \subsection \text{Pregnant at time of death} \ 5	□Ectopic pregnancy □ Other (specify)	Month	,
P.0.	that the ded by the detached	hys	9 Unknown			
	8 5 0	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part 1.	23e. Did tobacco use contribu	ute to the cause of death?  ☐ Probably 4 ☐Unknown
Š	w require been si should I	Completed			24a. Wasan 24b. We	re autopsy findings available
Rec	The lavate has	duic			autopsy prio performed? dea	re autopsy findings available or to completion of cause of th?  Yes 2 No
tal		a	25. Was case referred to medical	26. Place of Death (Che	A	Yes 2□ No
Σ	ysicii is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Cthor	5 Residence 6 1 Other	(Specify)
0	Attending Physician: r death. sctor: After this certific. by the funeral director.		27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time 1 Injury	Work?	Describe how injury occurred	
sio	death. ctor: A y the fu	cati	2 Accident investigation	M 1 Yes 2 No	ocation (Street and Number	or Gural Bauta Mumbar
Division of Vital Records,	after of Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s	treet, factory, office	City or Town, State)	or nural noute (vullber,
	Hospital 24 hours Funerel itely filled	Saic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 X Medical Examiner: On the basis of examination and/or in the basis of my knowledge, dea			
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	one) and manner stated.	29c. License number	29d. Date signed (f	
	7 × 10		29b. Signature and title of certifier			
^	de		30. Name and address of person who completed cause of death (Item 23a) (Type	OCME	December	13, 200)
9				. Baltimore, Maryland	d 21201	
	Sta			A i		
	Regist	rar	31. Date filed (Month, Day, Year)  DEC 2 1 2005	A STATE OF THE STA	4	

			State of Maryland / Den	artment of Health and Mental		
			POF	rtificate of Death	Reg. No.2	0
			Decedent's Name (First, Middle, Last)	2. Date	of Death 3. Time of Death	j
46	Physici /Medic		VICTOR		MBER 18 2005 4:40 A	М
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Funeral		MILFORD MANOR NURSING HOME  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	BALTIMORE  If Under 1 Year If Under 24 Hrs. 8. Date	of Birth th, Day, Year)  BALTIMORE  9. Birthplace (State or Fore	ign
BA S	Director		216-18-0026 1X M 2 F 85 Yrs.	Months Days Hours Min. 12/	of Birth with, Day, Year) 06/1920 9. Birthplace (State or Fore Country) GERMANY	
	land II		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or L	ocation	10d. Inside City Lim	its
	a-feh	tor	MD BALTIMORE BALTIM	ORE	1 ☐ Yes 2 <b>火</b> ☐	No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	eath v	erai	2149 WOODBOX LANE #A  11. Marital Status   12. Was Decedent Ever in U.S.   13.	Was Decedent of Hispanic Origin? (Specify Yes	or No- 14. Race - American Indian,	
9	after d	Fun	Armed Forces?  1 Never Married 2 Married   1 Yes, 2 No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e  1 ☐ Yes 2 ☑ No Specify:	tc.) Black, White, etc.	
21215-0036	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f ehow dical Examilian sunt by modified at	Completed by Funeral Director	3 Wildowed 4 Divorced Year or Dates:		Specify: WHITE	
15-	in 72 in	olete	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	
212	giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) MECHA	NICAL ENGINEER	WESTINGHOUSE	
pur	ould be filed Mental Hygis arked other atic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, I	,	
Maryland	should nd Men marke matic	٩		HEN THERESA ing Address (Street and Number or Rural Route	FROEHLICH Number, City or Town, State, Zip Code)	
	alth and 27 is mu		1 1 1 1	WOODBOX LANE #A - BAL		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show apprintury or other traumatic event, the Modical Experience stands for rediffied at ance.		20a. Method of Disposition 20b. Place of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CHECK DE ATT.	osition (Name of practory or other place)	20c. Location - City or Town, State	
ţi	permit. Pag Department Importent: eny injury once.		LHESED 1	NU. 1727207200	5 RANDALLSTOWN, MD	
Ba	Depa impo eny ir			22. Name and Address of Facility SOL LEV	INSON & BROS., INC PIKESVILLE, MD 21208	
			23a. Part 1. Enter the disease, or complication. Hat caused the death. Do not en shock, or heart failure. List only one cause on each line.		ttory arrest, Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Jewen tin	Onset and Death	wh
16	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
A.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
	acuted ind transit	Examin	Cause (Disease or injury that initiated events c			
,092	e be executed /sician and e burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of):			
99	death certificate t e attending physion of for use as the to		d			
Box	th cert lending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery  Month Day Year	
P.O. E		ysici	in the past 12 months?  1  Yes 2  No 9  Unknown	Other (specify)	MORITI Day rear	
	requires that the de neen signed by the hould be detached	Completed by Physician/Medi	Part IJ. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 236	Did tobacco use contribute to the cause of death?	
rds	w requires that been signed to should be deta	ed b	(A)		1 Yes 2 No 3 Probably 4 Unkno	wn
ecc	aw Is b	nplet	Atrial-fib	24a	. Was an autopsy autopsy findings availa prior to completion of cause of	ble of
al H	The ate		,		performed? death? Yes 2 No 1 Yes 2 No	
Z.	Physician: this certificant al director, j	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatie	26. Place of Death (Checker)  Other: 4 Nursing Home 5	only one)  ☐ Residence 6 ☐ Other (Specify)	
n of	E		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		scribe how injury occurred	
Division of Vital Records,	Attending or death.	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tyes 2 No	ation (Street and Number or Rural Route Number,	
Div	after after i Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier Contifier (Check only (Check only 2   Medical Examiner: On the basis of examination and/or i	ath occurred at the time, date and place, and due	to the cause(s) and manner as stated.	
	thin 24 thin 24 the F	Medi	one) and manner stated.  29b. Signature and title of certifies	29c. License number	29d. Date signed (Month, Day, Year)	
	F3F8		and my		12119105	
19	16		30. Name and oldress of person who completed cause of death (Item 23a) (Type	o, Print)	12/19/05 ce Pd 2/208	
1			31. Date filed (Month, Day, Year) 32. Regigrar's Signature	38 Oreens 1-	ee 14 lins	
	Sta Regist		DEC 2 2 2005	Location		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 3:10 P <sup>™</sup> Antoinette Mary Caruccio December 2005 11. /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death Examiner Manor Care Baltimore Towson 8. Date of Birth Month, Pay, Yea. 6/13/1911 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🕱 F 94 214-03-4888 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TYes 2 X No MD Baltimore Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Virginia Avenue Apt. 1112 21286 U.S.A items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐Yes 21 No Yes, Give Baltimore, Maryland 21215-0036 ò 1 Yes 28 No Specify: Specify: White 3<sup>™</sup> Widowed 4 □ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental t Jack La Macchia Mary Greco Conzila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Holy/Daughter 3800 Meghan Drive Unit 1C Baltimore, Maryland 21236 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ± 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö rtment: i 12/19/05 Gardens of Faith <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland permit.
Dep. rtm
Importa
any inju 21. Signature of Funeral Service Licen 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ode of dying, such as cardiac or respiratory arrest, Immediate Cause (Float Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the IF FEMALE esn If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ρ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 dinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 2 No 2FTNo 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. 1 TYes 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 / Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I complet 29b. Signature and title of certifier oc License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp ause of death (Item 23a) (Type, Print) TOWSONF. 72 a. 51613 10 17. KHAO MY KMY IV 7661 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Topped . DEC 2 2 2005 Registrar

in Delano 13/15/05 12 pm

			Please 1	ype or Prin							_	
	-24-0-24-0-24-0		1 - For State Registrar	State of Ma	-		tificate of		d Mental Hy	ygiene Reg. No	DOOF	41105
	Physicia	an	1. Decedent's Name (First, Middle, Last,						2. Date of D Month	Da	y Year	
	/Medic Examin	al	DORIS ELLEN  4a. Facility Name (If not institution, give	DELANO street and number)			4b. City, Town, or	r Location of Di	Dec.		15 2005   12:06 p M 4c. County of Death	
	LAGITITI		Gilchrist Center				Tows			Baltim		
*	Funeral Director		120 20 1212	7. Agu	o (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of 8. Month, D. January	irth Day Year) / 4,19	25 Mi	inthplace (State or Foreign Country) SSISSIPPI
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation				<del></del>	10d. Inside City Limits
	Mary B-f sh	io	Maryland N/A		Baltimo	timore						Y No 2 □ No
	with the	I Directo	10e. Street and Number 111 Hamlet Hill R	oad #1303	1303		10f. Zip Code 2121		10g. Cit	tizen of What C	Country?	
036	be filed within 72 hours after death with the Maryland tal Hyglene d other then "natural", or iteme 23a or 28a-f show event, Ire Micilial Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married AMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S.		í	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes XXNo Specify:			lo-	14. Race - Am Black, Wh Specify:	
ပ ၁	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a.	Deced (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)		working	16b. K	and of Busines	s/Industry
	l within liene.	Completed	Elementary/Secondary (0·12)	College (1-4or 5	+)		omemaker	2)			Own Ho	ome
and	be de la de	To Be C	17. Father's Name (First, Middle, Last) Edward Caillavet						Name (First, Middl B Collins			
Baltimore, Maryland 21215-0036	ges 1 and 2 should it of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7) Arthur A Delano Jr				g Address (Street Old Trail					
imore,	Pages 1 and of the next of the next of the next if item arry or other		20a. Method of Disposition  **TXBurial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	v. cren	position (Name of ematory or other place)  City Cemetery 12/19/05  Biloxi, Mississip						
Balti	permit. Pag Department Important: I eny injury o	21. Signature of Funeral Service Licenses  22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc 6500 York Road Baltimore							Inc.	farvl and	d 21212	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or dompi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each lir a	the death. Do not not not not not not not not not no	19		ng, such as car		,		Approximate Interval Between Onset and Death
134		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	a consequence o							
68760,			555 15 (6) 655 557									
O. Box (	The law requires that the death certificate sie has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	,			23d. Date of d Month	elivery Day Year
a.	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
ğ	w require been sig should b		multiple s	troices,	dem	en	tin		- 10	Yes 2	JX1/10 3□1	Probably 4 Unknown
Division of Vital Records,	The law roote has be page 2 sh	Completed							24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to death?	aulopsy findings available completion of cause of ss 2 \sum No
Vita	sician certific rector	Be	25. Was case referred to medical examiner?	Hospital:			. all post Oth	or	Death (Check only		a bou us	11/1000
o	Attending Physician: sr death. ector: After this certifice by the funeral director, p	n: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie		tpatier Fime of njury	I 3 DOA	4   NUISII	g Home 5 ☐ Re 28d. Describe		6 Other (Sp occurred	recity) HOSPICE
Sior	sandin eath. or: Aft	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No				
$\frac{1}{2}$	i or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	rm, str	eet, factory, office			(Street ar own, State	and Number or Rural Route Number, ate)	
	To the Hospitel or Attanding Physician: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best iner: On the basis of and manner sta	examination an	d/or in	n occurred at the tirvestigation, in my o	me, date and p pinion, death o	lace, and due to the	e cause(s e, date an	) and manner of diplace, and di	as stated. ue to the cause(s)
ı	To the To the comple	Me	29b. Signature and title of certifier	my Ril	leg. v	4)	29c. Licens	se number 5 205		29d. Da	ate signed (Moi	er 15, 2005
0	/>		30. Name and address of person who c	completed cause of a	670/	Туре,	Charle:	St. 1.	Balto 1	n d	2120,	er15,2005 *
X	Sta	te	31. Date filed (Month, Day, Year)	32. Registe	er's Signature							

		1	st <b>Amend Item#14</b>	State of Moreon FH G85	aryland / Depa 50 12/21/05	artment of H	lealth and Death		ene 005	41107	
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month						Day Year	3. Time of Death	
	/Medic				ne DeShield			12	11 05	8:00a.M	
<b>X</b>	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		ath	4c. County of Dea	th	
			4405 Maine Ave.  5. Social Security Number 6. Se	7 40	ge (In yrs. last birthday)	If Under 1 Year	imore	S. 8 Date of Birth		thplace (State or Foreign	
	Funeral Director				64 Yrs.	Months Days	Hours Mir		Year) Co	Md.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of the Health and Mental Hygiene. It health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-1 show other traumatic svant, the Mayleal Examinational be notified at		Usual Residence of Decedent								
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		cto	MD NA		Baltimo	re				1 Dygs 2 □ No	
		Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
		ra	4405 Maine Ave			212			U.S.A		
		by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:	Mo	was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi		
	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occup	during most of w	orking	16b. Kind of Business	/Industry	
121	12 should be filed within 'h and Mental Hygiene. 7 Is marked other than 'r traumatic avant, tha Mau	Igm Igm	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired Comemake			House		
CA	lled v lygie ther t nt, in		9th grade  17. Father's Name (First, Middle, Last)	na	1.	Omemake		ame (First, Middle, N	House	!	
Maryland	ntal h	Be	James Anderson	,				ia Wilso	· ·		
Z	hould d Me mark matic	ပ	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street		211/12	City or Town, State,	Zip Code)	
Ma	od 2 s lith ar 27 ls r trau		Howard DeShie.					altimore		2107	
Baltimore,	1 an Heal tem 2	0	20a. Method of Disposition		20b. Place of Dispo		T		20c. Location - City or	Town, State	
	Pages nent of h ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Wood1		1	20/05 B	altimore	DM OD	
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It sny injury or other tra 2008.		21. Signature of Funeral Service Licen			Name and Addre			imore, Md		
ä			/ Womann t	1. XILLA	Mt 1	March F.H	. West		abash Ave.		
			23a. Prit1. Enter the disease, or company, or heart failure. List only	olications that cause	d the death. Do not ent	er the mode of dyin	g, such as cardi			Approximate Interval Between	
	Physician // Medical Examiner physician and physician and the phural-transit the physician structure of the physician structure o		Immediate Cause (Final Idea and Death Importance Cause (Final Ideas or condition Fesulting in death)  a. Alternos devotro Cosoli ovosculor US  Due to (or as a consequence of):								
			Sequentially list conditions, b.								
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	( -					
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
90,											
. Box 68760,	cate b	dical		d							
	death certific e attending p id for use as	Completed by Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1						23d. Date of de Month	livery Day Year	
P.0	hat th ed by detacl	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobat  24a. Was an autopsy performe						acco use contribute t	co use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ Unknown	
ds,	8 2 0	d by							s 2 No 3 P		
Ö	The law ate has b page 2 sl	ete							24h Were a		
Re		Ę.							ned? death?		
a			25. Was case relerred to medical				26 Place of D	eath (Check only one	No 1 Yes	2000	
Ξ		o Be	examiner?	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Outpatie	nt 3 DOA Oth		h 2	nce 6 □Other (Spe	acifu)	
of	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Inju				28d. Describe ho		(Control of the Control of the Contr	
on	Attending r death. sctor: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation								
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined							lural Route Number,	
		edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	omple	₹ E	29b. Signature and little (Certifier 29c. License number 29d. Date signed (Month, Day, Year)							h, Day, Year)	
	~ s ⊨ ō		1 1 1 1 900 V/ 3 1 1 2 -1.5/0 F								
-	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
1	10		M. Brockington		Rolling		Road, C	atonsvil	le, Md	21228	
1 3	St	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	_					
4-3	Regist	rar	DEC 2 1 200	15 Maria	. M. Con	100					

Vital Records, P.O. Box 68760, Programme Baltimore, Maryland 21215-0036	ician: The law requires that the death certificate be executed	certificate has been signed by the attending physician and inportant: if item 27 inportant: item 27 inporta	Be Completed by Physician/Medical Examiner
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of nearth and mental rygistie. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified at once.  one.	To Be Completed by Funeral Director

		For	State of Ma						-	•	ole. 15   11	10
		- State Registrar			Cei	tificate	of Deat			Reg. No.		JO
Physicia	an	Decedent's Name (First, Middle, Last)  2. Date of Death Month						Day	3. Time of D			
/Medica	al .	Robert H. Doyle  4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death			mber 18, 2005 4:00 P M  4c. County of Death		
Examine	er	9000 Marseille					omac	n or Death			gomery	
Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Y		er 24 Hrs.	8. Date of Birth	n	9. Birthplace (State or Country)	Foreign
Director		024-10-4700	1⊠M 2□F	81	Yrs.	Months D	ays Hours	MIN.	(Month, Day larch I	3,1924	Massachuset	ts
and and	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City	Limits
Mary l	by Funeral Director	Maryland Montgom	nerv	Pot	omac						1 ☐ Yes 2	2 <mark>₩</mark> No
or 288		10e. Street and Number				10f. Zip Co	ede			10g. Citizen of W	Vhat Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at 2008.		9000 Marseille D	rive			2085					States	
sr des		11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent f Yes, specify	t of Hispanic ( Cuban, Mexic	Origin? (Spec can, Puerto F	cify Yes or No- Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.	
I', or		1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:			1□Yes 2🏝	No Specia	fy:		Specify	White	
2 hou		15. Decedent's E	Education		6a. Deced	dent's Usual O	ccupation			16b. Kind of Bu	siness/Industry	
thin 7	Completed	(Specify only highest gi	College (1-4or 5	5+)	life.	kind of work of DO NOT use r	etired)	OSI OI WOIKIII		0 1 D	•	
lygien lygien her th		47 Fathada Nama (First Middle Los	5+	1		Attorne		thada Nama			oprietor	
otal H	Be	17. Father's Name (First, Middle, Las Hillard V. Doyl							Griffi	Maiden Sumam	θ)	
should nd Me mark matic	ဍ	19a. Informant's Name/Relationship		1	9b. Mailir	ng Address (S					State, Zip Code)	
nd 2 saith ar 27 ts r treu		Suzanne Huber Doy									nd 20854	
s 1 a of Heal item	Ì	20a. Method of Disposition		20b. Place	ol Dispo	sition (Name on atory or other	of r place)		ate 22	20c. Location -	City or Town, State	
Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec			lahri	e1's Ce	meterv	200	per 23,	otomac,	Maryland	
permit. Depertr imports any inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockyille, Inc. 300 West Montgomery Avenue.										
40 E = 0	_	Gart J. Ko	Skins MOI									
k — — — — —		23a. Part 1. Enter the disease, or cor shock, or heart fallure. List only Immediate Cause (Final	,	ne.			i aying, such a	as cardiac or	respiratory ari	rest,	Approximate Interval Betwee Onset and De	
Physician /Medical		disease or condition resulting in death)	Myocar		_	etion						
Examiner		Atherosclerosis										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury										
acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
	ai Ex	resulting in death) Last  Due to (or as a consequence of):										
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the			d									
nding use a	₩ Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Te				23d. Date	e of delivery	
death e atte	Physician/Medi	1   Live birth   2   Fetal death   3   Ectopic pregnancy							Mor	Month Day Year		
at the	Phys	9 Unknown										
res th signed be de	<u>م</u>	Hyportension							ibute to the cause of dea 3 ☐ Probably 4 ☑ Un			
requi	Completed											
he law s has ge 2 :	d L	Chionic obstitue	cive raimo	nary D.	1504				24a. Was a autop perfor	med?   d	Vere autopsy lindings av Prior to completion of cau leath?	se of
in: Ti		25. Was case reterred to medical					26 Pla	ce of Death	1 Yes		Yes 2 No	
ysicia Is cert direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/	Outpatier	it 3 DOA	Other			ence 6 Othe	er (Specify)	
ng Ph Iter th neral		27. Manner ol Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28	b. Time of	28c.	Injury at Work?			ow injury occurre		
eath. or: Al	catle	2 Accident investigations 3 Suicide 6 Could not	on he			М	1 Yes 2		-11-1			
or At	Certification:	4 Homicide determine	d 200. Place of Inj	ury - At home c. <i>(Specify)</i>	, larm, str	eet, lactory, of	ffice	2	8I. Location (S City or Tow	itreet and Numbern, State)	er or Rural Route Numbe	9 <i>r</i> ,
spital ours a nerai filled		29a. Certifier 1 🔀 Certifying F	Physician: ∦o the best	of my knowled	dge, deatl	n occurred at t	he time, date	and place, a	nd due to the o	ause(s) and ma	nner as stated	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificete his completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)										
To th withir To th comp	ž	29b. Signature and title of cartifier	10	1		29c. L	icense numbe	ır	2	29d. Date signed	(Month, Day, Year)	
111	_	Y Wast K	< Jolly	W			D03581			December	r 19, 2005	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot R. Goldstein, M.D. 6000 Executive Blvd., #3							#300	Doole	110 Ma	w1am 1 200E	2	
Stat	e.	31. Date filed (Month, Day, Year)					TAG. 2	, 500	NOCKVI.	iie, Mar	y Land 2003	
Registra		DEC 2 1 2	005	ar's Signature	ADE							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylar		artmen tificate			nd M	ental Hy	giene	000	week standard	109
ź	Physici	an	1. Decedent's Name (First, Middle, La	ast)							2. Date of De Month		y Yea		. Time of Death
	/Medic		Donald			Ford					12	-			12:15p™
	Examin	er	4a. Facility Name (If not institution, gi		)				Location of	f Death		4c.	County of De	ath	
-	生		1224 E. Chase 5. Social Security Number 6.		ne (In vrs.	last birthday)		altir 1 Year	nore If Under 2	24 Hrs.	8. Date of Bir	th	NA 9 B	irtholace	(State or Foreign
	Funeral Director		217–56–8019	M 2□F	57	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year) -7-4	(	Country)	S.C.
	1 40		Usual Residence of Decedent	Λ	-, -							, -20	5		D.C.
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo									Inside City Limits
	Ba-f e	cto	Md. NA			Balt	imore								Yes 2 No
	hours after death with the Maryland tural', or Items 23e or 28e-f ehow al Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip	Code 212	202				izen of What ( USA	Country?	•
	s 23e	rai	1224 E. Chase S		Francia II	15 7423	W D			:-0 (0	- Y - V N		14. Race - An	a dogg I	ndina
_	Item	in in	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces	?	7.3.	f Yes, spec	cify Cuba	n, Mexican,	Puerto F	cify Yes or No Rican, etc.)	)-	Black, Wh		ridiari,
5	urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	,,,,		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: B	lack	
9500-61212	172 hours after death with the Marylan "natural", or Items 23a or 28a-f show olical Exemirer must be notified at	Completed	15. Decedent's E	ducation		16a. Dece				of working	_	16b. K	ind of Busines	s/Indust	гу
2	within 72 ene. than "na	ple	(Specify only highest gi	College (1-4or	5+)	life.	DO NOT us	se retired	luring most )	OF WORKIN	ig .				
	be filed within 72 ho tal Hygiene. d other than "natur event, the Modical	Con	12th grade			Pos	tal S	Servi					st Off	ice	
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Las	t)		<b>7</b> 1					(First, Middle	, Maiden		ice	
<u>Z</u>		10	Ansel		Ford			400		ctor					
ā	12 g h ar 7 ls		19a. Informant's Name/Relationship				•				Baltim		n Town, State	. <i>Zip C</i> 00 21.20	
	an m 2		Joretha Fordham 20a. Method of Disposition	Sist	20b. I	Place of Dispo	sition (Nan	ne of			ate		ocation - City o		
٥	Pages nent of ant: If It ary or o		1√2 Burial 2 ☐ Cremation 3			cemetery, crer	natory or o	ther place	1		05				
Baitimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		G	arrison			et. 1				ings M		
g	Depri Impo		#	17	21				I. Eas				e, Md. North		.202
-	-38		23a. Part1. Enter the disease, or con	nplications that cause	d the dea								NOL CIT	Ap	proximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	ine.	RAiL	UNE	}							erval Between set and Death
	Examiner			Due to (or as	a consec	quence of):	( 1	4 11	G C	MNC	AR.			2	inorthe
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consec			<i>/ (</i> ) ( )	of C	,,,,,,,					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0											
oʻ	te be executed ysician and se burial-transit		resulting in death) Last	Due to (or as	a consec	quence of):									
7,60		ical		d										ļ	
RG C	death certifical e attending phy id for use as th	Med	IF FEMALE:											<u> </u>	
X Q R	ath ce ttendi	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Feta	al death 3	Ectopic pr						23d. Date of d Month	elivery Day	y Year
0	0 0 0	sic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown	it time of c	death 5□	Other (sp	ecify)						50,	, , , ,
٦.	hat the	Ph	Part II. Other significant conditions	contributing to death I	out not res	sulting in the u	nderlying c	alise dive	n in Part I		23e. Did 1	tobacco i	use contribute	to the ca	ause of death?
Records,	The law requires that the tee has been signed by thoage 2 should be detache	d by	HEAD AND	WELK	CAN	TER	ild dily iligio	acco g			1	,			4 □Unknown
Š	w require been signature	ete	IM ? ERTON	CIENI							24a. Was		04h 14/222		findiana available
ĕ	he lav	Completed	CIO( & CALL CAR	2(0/0							auto		prior to	compte	findings availabte etion of cause of
		e Co	25. Was case referred to medical						00 01	-4 D45	1 Yes	$\sim$	1 🗆 Ye	s 2	] No
VItal	Physician: r this certific ral director,	8	examiner?	Hospital: 1 Dinnati	ent 2	ER/Outpatien	it 3 DC	Othe		sing Hom	(Check only		6 □Other (Sp	acufu)	
Ö	arthis eral c	n: To	27. Manner of Death	28a. Date of Inju	ury	28b. Time of		28c. Injury Work			8d. Describe			ochy)	
<u></u>	Attending Fire death.  ector: After by the funer.	atio	i Natural 5 ☐ Pending 2 ☐ Accident investigate	on (Month, Da	ту тваг)	Intury	М		/es 2 □ N	10					
Division of		Certification:	3 ☐ Suicide 6 ☐ Could not determined		jury - At h	iome, farm, str	eet, factory	, office		2	8f. Location ( City or To		d Number or i	Rural Ro	oute Number,
5	tal or A	Cer		Dunium, g, c									,		
	To the Hospital or within 24 hours afte To the Funeral Direction Completely filled in I	edical	29a. Certifier Certifying P	hysician: To the best iminer: On the basis of	of my kno	owledge, death	occurred	at the tim	e, date and	d place, a	nd due to the	cause(s)	and manner	as stated	i. cause(s)
	To the hwithin 24	Med	one)	and manner s	tated.										
	No.	-	29b. Signature and title of certifier	( 0.0			290	License	пишоег	i		290. Da	le signed (Moi	ioi, Day,	rear)
	11 -		MINIM	> IND	4		1'/	4/	75	<u> </u>		1 4	11,))	40	0)
5	Y)/	2	Name and address of person who		death (Iter	m 23a) (Type,	Print)	0	AZE	1	AUTIN	ent	CIM -	2 /	12 87
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist		ature	4/10	_ 8	-1 (0)	- 46	210111		140)		, 00
	Registr		DFC 2	1 2005	10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	. B	Augus	عري							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:45 a. M Marie K. Fortune 12 7 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3801 Fernhill Avenue 8. Date of Birth (Month Day, Year) 1 – 21 – 1929 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min 235-42-9641 1 ☐ M 2 🗓 F 76 Yrs Director West Va Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. 27 is marked other then "natural", or Iteme 23a or 28a-f show treumatic event, the Medical Examinar must be routlled at 1 Yes 2 □ No Director Md N/ABalto 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3801 Fernhill Avenue 21215 U S by Funeral Α Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Educator & Administrator Public Schools 12th grade 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Kinney ဥ Ruth Ester Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t Health Lisa McDonald - Daughter 4301 Ayrdale Avenue Balto, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 12-22-2005 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyrjeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arctio Vinsular **Physician** /Medical Due to (or as a consequence of) Examiner em Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Just to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit 866 Due to (or as a consequence of) physician Box 68760 Physician/Medical the IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Arteries clorosis 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 2/2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2/10 No 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours aft To the Funeral Di Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/20/05 D15938 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd RANDAUSTONMM 2113 YUNYON GYING 060 MALINEE 5400 COURT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINA

DEC 2 1 2005

	For State Registrar	State of Maryland /	Department of Health and Certificate of Death	I Mental Hygien Reg. N	2005 / 1111
Physician	1. Decedent's Name (First, Middle, Last			2. Date of Death	ay Year
/Medical Examiner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De		c. County of Death
Funeral Director	5. Social Security Number 6. Se 219-26-3586		oirthday) If Under 1 Year If Under 24 H  Yrs. Months Days Hours M		9. Birthplace (State or Fore Country)  Maryland
death with the Maryland rms 23a or 28a-f show rms 1 te rollified at neveral Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo	10c. City, To	wn or Location		10d. Inside City Lim 1 ☐ Yes 2 🔀
with the Mar a or 28a-f s be routing	10e. Street and Number	16 , 26262	10f. Zip Code		itizen of What Country?
urs after death very or thems 23c		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	21221  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 □ Yes 2 ☒ No Specify:	(Specify Yes or No-	S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
ed within 72 hours alt ygiene. her than "naturel", or t, the Medical Everal	15. Decedent's Edu (Specify only highest grad	ucation 16 te completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired)	vorking	Kind of Business/Industry
yidiliu A vuld be filed v Mental Hygie arked other stic event, th	17. Father's Name (First, Middle, Last)			Re ame (First, Middle, Maide rite Ludwig	estaurant on Sumame)
partitioner, Mailylania 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (T)  Steven George, Sc  20a. Method of Disposition  1 □ Burial 2 【X Cremation 3 □ II	20b. Place cemet	1019 Foxwood Lane, of Disposition (Name of ery, crematory or other place)	Baltimore, M	ID 21221 Location - City or Town, State
Daltiii permit. Pa Departme Important any Injury once.	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		22. Name and Address of Facility Charles S. Zeiler		onsville, MD
Physician / Medical cian and parallel can and parallel can and parallel can all Examiner all Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arrhythmic  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	e of): heart fail e of):	Fibrillat	Approximate Interval Between Onset and Death
The COLUS, F.C. BOX 00 (00).  The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	th 3 Dectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
w requires that the been signed by should be detailed by Ph	Part II. Other significant conditions co	intributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death
				24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death?  1 Yes 2 No
Physician: this certific ral director,	examiner?	Hospital: Inpatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing	eath Check only one Home 5 Residence	6 Other (Specify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (		(Month, Day Year)	Time of Injury at Work?  M 1 Yes 2 No	28f. Location (Street a	ury occurred  and Number or Rural Route Number,
he Hospital or A in 24 hours after he Funeral Dire pletely filled in b edical Certif		building, etc. (Specify)  rsician: To the best of my knowled	ge, death occurred at the time, date and pla	City or Town, Starce, and due to the cause(	s) and manner as stated.
	one)	and manner stated.	and/or investigation, in my opinion, death oc	curred at the time, date ar	nd place, and due to the cause(s)

			1- State of Maryland /		artment of F			giene Reg. No.	005	4112
	Physici	an	Decedent's Name (First, Middle, Last)  CHARLES PAYMOND HIGHES				2. Date of Dea Month	Day	Year	3. Time of Death
j.	/Medic		CHARLES RAYMOND HUGHES  4a. Fecility Name (If not institution, give street and number)		4b. City, Town, o	r Location of	DECEMBER Death		2005 County of Dear	
			MAGNOLIA CENTER		LANHA			F	RINCE	GEORGE'S
	Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex  1 ☑ M 2 □ F  80	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day	y, Year)		thplace (State or Foreign country)
	9		Usual Residence of Decedent				JUNE 6,	192	2   INI	DIANA
	farylar et al	ō	10a. State 10b. County 10c. City, To MARYLAND PRINCE GEORGE'S BO	own or Lo	ocation					10d. Inside City Limits 1 √ Yes 2 □ No
	r 28a-f	Director	10e. Street and Number	WIL	10f. Zip Code			10g. Citiz	en of What Co	1
	23a o		13442 OVERBROOK LANE		2	20715		U.S	. A.	
	er dea	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origir an, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	1-	4. Race - Ame Black, Whit	
936	al', or	by	1 □ Never Married 2 □ Married 1 ሺ Yes 2 □ No If Yes, Give Year or Dates: 1942-50	)	1□Yes 2∏ No	Specify:		3	Specify: W	WHITE
2-0	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow ha Madical Examinar must be notified at	Completed		Sa. Deced	dent's Usual Occup	durina most o	of working	16b. Kin	d of Business/	/Industry
12	within iene. than	ompi	Elementary/Secondary (0·12) College (1-4or 5+)		DO NOT use retired DMAN	1)			GHT PORATI	ON
g	al Hygid	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middle,			OIV
Z	2 should be i and Mental i is marked o aumatic eve	고	CHARLES RAYMOND LEE			IOLA	CATHERINE	CAI		
<u>e</u>	and 2 shealth and m 27 is n						or Rural Route Numbe E, BOWIE, M	•		Zip Code) 0715
Baltimore, Maryland 21215-0036	- T - =		come	of Dispo	sition (Name of matory or other place	(a)	Date	20c. Loc	ation - City or	Town, State
Ĕ	Pages tment of t tant: If It jury or o		The state of the s		MATORY					ARYLAND
Ba	permit. Pag Department Important: I any Injury o	l,	21. Signature of Funeral Service Licensee				ROBERT E.			
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.						ICLERICE	Approximate Interval Between
į.	Physician		Immediate Cause (Final disease or condition	VVY	Herri H 3					Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence)			1	. ) 0			
Ę	***	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	e of):	Kterry	ou les	() (			
V	ecuter end I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	NI	Heiral	Dillea	1e.			
8760,	cate be executed physicien end the burial-transit	dical E	d. Dol Munal							
89		Medic	IF FEMALE:							
Box	attendii for use	ian/I	23b. Was decedent pregnant  1 Live birth 2 Fetal dea		Ectopic pregnancy			23	3d. Date of del	ivery Day Year
P.O. Box	the de by the a	Physician/Med	1 □ Ves 2 □ No 9 □ Unknown 4 □ Pregnant at time of death	5_	Other (specify)					
o, O	w requires that the death certif been signed by the attending should be detached for use a	by Pi	Part II. Dther significant conditions contributing to death but not resulting	j in the ur	nderlying cause give	en in Part I.		_		the cause of death?
or D	requir	eted	Dementia				1 97	es 2□		obabły 4 Unknown
Rec	The law cete has t page 2 s	Completed	Chan's Althoria.				24a. Was a autops perfor	an sy med?	death?	stopsy findings available completion of cause of
ā	ician: Th certificete rector, pag	Be Co	25. Was case reterred to medical examiner?			26. Place of	1 ☐ Yes f Death (Check only or		1 ☐ Yes	2□ No
Division of Vital Records,	Physician: r this certifice ral director, p	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/0			4 🗀 INUISI	ng Home 5 ☐ Resid			cify)
50	ding I th. : After s funer	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	. Time of Injury	Worl	/at ∢? Yes 2∐No	28d. Describe h	ow injury	occurred	
<u>S</u>	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	larm, str	eet, factory, office		28f. Location (S City or Town	treet and	Number or Ru	ural Route Number,
	pitel o									
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; g	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death and/or inv	n occurred at the tim vestigation, in my or	ne, date and pointion, death	piace, and due to the c occurred at the time, d	ause(s) a late and p	nd manner as lace, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	R	29c. License			9d. Date	signed (Monti	h. Day, Year)
)	OH		I my p cerugar			0905	/	13	- / - ( '	>
	'2'		30. Name ind address of person who completed cause of death (Item 23a	a) (Type,	Bour	K, M	0 207	15		
	Sta Registr		31. Date filed (Month, Day, Year)  DFC 2 1 2005  32. Registrar's Signature	nost.						

		•	For Stata Registrar	State of	Marylan		artment rtificate			d Mental Hy	giene	5 41113
П	Physici	an	1. Decedent's Name (First, Middle, L	^	1JA	RTW	ELL			2. Date of De Month	Day	3. Time of Death
	/Medio		4a. Fecility Name (If not institution, g	<u> </u>		1-100			ocation of (	DECEM	4c. County of	2002 1.
	Examir	er	Howard County G				45. Oky,		columb		Howa	
	Funeral				Age (In yrs.	last birthday)	If Under	1 Year   I	If Under 24	Hrs. 8. Date of Bir	th	
	Director		232-42-8405	1□M 2∏F	74	Yrs.	Months	Days	Hours	Min. Apr. 1	1, Year)	9. Birthplace (State or Foreign Country) WV
	pc ,		Usual Residence of Decedent		10- 01	v. Town or Lo						
	aryla shov	7	10a. State 10b. County		100.010		_					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Na M	Director	MD Howar  10e. Street and Number	<u>d</u>			Dayto 101. Zip				10g. Citizen of Wh	Λ
	with with		4999 Morningsta	r Drive			101. Zip	210	136		USA	at Country:
	within 72 hours after death with the Maryland ane. then "naturel", or Itams 23a or 28e-1 show te Modical Examinar must be notified at	Funerai	11. Marital Status	12. Was Deced		S. 13.	Was Deced			1? (Specify Yes or No Puerto Rican, etc.)		- American Indian,
9	or Itan	F	1 Never Married 2 Married	Armed Ford	X No					uerto Rican, etc.)		White, etc.
03	rel', c	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes 2	NO L	Specify:		Specify:	White
21215-0036	72 h	Completed	15. Decedent's (Specify only highest of			/Giva	dent's Usua kind of wor	k done dur	on ring most o	f working	16b. Kind of Bus	iness/Industry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4	for 5+)	i	ice A		at mat	- 0.10	Shell (	Dil Company
	Hygie Hygie othari ant, II		17. Father's Name (First, Middle, La	st)		OLL	ice A			Name (First, Middle,		
an	d be antal ced o	To Be		oone						zel Jeane		
Maryland	shoutd nd Men marke umetic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street and	d Number	or Rural Route Numbe	er, City or Town, S	tate, Zip Code)
	and 2 salth a n 27 le		Mr. Wesley Hartw	ell (Spou	se)	4999	Morn	ingst	ar Dr	ive Dayto	n, MD 210	036
J.	of Her item		20a. Method of Disposition		1 ^	lace of Dispo	sition (Nam	ne of ther place)	1	Date	20c. Location - C	ity or Town, State
Ē	Pages nent of I ant: If its ury or o		1 ∑Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		Cre	st1awn	Mem.	Gard	lens 1	.2/21/2005	Marriott	sville, MD
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Items 23a or 28e-1 show any injury or other treumetic event. It is Micdical Examinar must be notified at once.		21. Signature of Funeral Service Lic	Haid	_	Î	ATGHT ykesv	Address FUNE ille,	of Facility CR L H MD 2	OME & CHA	EL PA )-795-14(	(Box 195)
	Physician /Medical		23a. Part1. Enter the disease, or oc shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	a A C	used the death th line. UTE r as a conseq	MYD		of dying,	such as ca	JPARC T	rrest,	Approximate Interval Between Onset and Death 2 1700K
0,	sate be axecuted bhysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	r as a conseq							
68760,		edical		d								
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta ntattime of d	death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>				23d. Date Mont	
ds, P	uires that signed t	þ	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying ca	nevig given	in Part I.	2	/	oute to the cause of death?
al Records,	stcien: Tha law requir certificate has been si irector, page 2 should I	Completed								24a. Was autor perio 1  Yes	osy pri ormed de	ere autopsy findings available or to completion of cause of ath?
<u>Xi</u>	sicier certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		for		Other		Death (Check only o		(0 " )
of	this al d	7: To	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		Bc. Injury a Work?	4 LI NUISI	ng Home 5 Pesid 28d. Describe I	how injury occurred	
ion	nding th. :: Afte e func	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		, Day Year)	Injury	M		s 2 No			
Division of Vital	al or Atter s after des 1 Director d in by the	Certification;	3 Suicide 6 Could no 4 Homicide determine	ad 28e. Place c	of Injury - At ho g, etc. (Specif	ome, farm, st	reet, factory	, office		28f. Location (S City or Tox		or Rural Route Number,
	To the Hospital or Attending Physicien: Tha within 24 hours after death.  To the Funeral Director: After this certificate his campletely filled in by the funeral director, page	Medical C	29a. Certifier Check only one) Check only	Physician: To the bas aminer: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the time, in my opin	, date and p nion, death	place, and due to the occurred at the time,	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)
	To the To the comp	Me	29b. Signature and little of certifier	Mau	10	MD	29c	) dicense of	790	9	29d. Date signed of DECEMB	ER 16,2005
1	0/2		30. Name and address of person with SCOTT MAUR	no completed cause	of death (Item	23a) (Type	Print) UT	E 9	7 5	SVITE 1	10 GLEI	an anow
	Sta	ate	31. Date filed (Month, Day, Year)	9 1 2005N	gistra s Signa	iture	123					21738

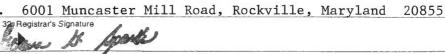
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year December 14, 2005 **Physician** Quai Huynh 12:07 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery | KOCKVIIIC | If Under 14 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 2, 19 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Director 217-04-7780 63 1942 Vietnam Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event. The Madical Examinar must be notified at 1 Wes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 Perrywinkle Lane 20878 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after ☐Yes 2X No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembler Solar Company is 1 and 2 should be filed voil Health and Mental Hygie Item 27 is marked other 27 is marked other item 27 is marked other item 27 is marked other 27 is marked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Hoa Huynh Cau Luu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nhuan Luc Huynh/Wife 236 Perrywinkle Lane, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny Injury or ott December 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 17, 2005 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 uneral Service Lio 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 40 ca disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ≥ No 2 A ER/ utpatient ို 1 Inpatient 3 DOA this After thi 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural death 1 ☐ Yes 2 ☐ No Director: / Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number Decumber 14, 2005 040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rock, 1/2, MJ 20850 Center Drive Gama 9901 Mudical 32. Registrar's Signature 31. Date liled (Month, Day, Year) State DEC 2 1 2005 Registrar

			1 _ State	State of Ma	aryland		rtment o			ental Hy	gierie	005	1115
			Registrar  1. Decedent's Name (First, Middle, Last)			Cei	uncate	Deall		2. Date of De	Reg. No.		3. Time of Death
	Physici	an								Month	Day	Year	
	/Medic		Praxedes C. Herr				4b. City, Tow	n, or Location		December		2005 County of Deat	11:30 P M
	Examin	er	Montgomery Hospice		nuse		Rockv		., 0. 200			ntgomer	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. la	st birthday)	If Under 1 Yo	ar If Unde	er 24 Hrs.	8. Date of Bir			J
*	Director		213-88-8131 1 Dsual Residence of Decedent	M 2 <b>X</b> ]F 8	35	Yrs.	Months Da	ys Hours	Min.	8. Date of Bir Month, Da July 21	, 192	0 Phí	hplace (State or Foreign untry) lippines
	yland		10a. State 10b. County		10c. City,	Town or Lo	ation						10d. fnside City Limits
	B Ma	ctor	Maryland Montgomer	У	Ger	mantov	m .						1 ☐ Yes 2Ã No
	or 28	Directo	10e. Street and Number				10f. Zip Cod	le			10g. Citi.	zen of What Co	untry?
	ath w	Ta .	11612 Lucrece Terr				208					lippine	
	er de Itams	Funerai	Tr. Wanta States	2. Was Decedent I Armed Forces?		.   13. V	Vas Decedent Yes, specify (	of Hispanic C Cuban, Mexic	Origin? (Spec can, Puerto F	cify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, White</li> </ol>	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-f ehow other traumatic event, II.a Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N ff Yes, Give Year or Dates:	NO		□Yes 2X		fy:				sian
5	"nat	ete	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	ent's Usual Ockind of work do OO NOT use re	cupation one during mo tired)	ost of workin	ıg	16b. Kii	nd of Business/	Industry
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7 5	filed Hygi other		17. Father's Name (First, Middle, Last)				memare		ther's Name	(First, Middle			
yland	id be ked of ic ev	To Be	Eugenio Calingasa	n				In	ez Ado	ptante	:		
	shound M	-	19a. Informant's Name/Relationship (Typ	e, <i>Print)</i>		19b. Mailin	g Address (Str					r Town, State, 2	Zip Code)
Mar Mar	and 2 alth a 127 is		Carmencita H. Abut	aa/daught	er	11612	Lucre	e Ter	race,	German	town	, MD 2	0876
ย์	of Health of Health if Item 27 I		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	mayal from State	20b. Pla	ce of Dispos	sition (Name o	place)	Decemb	ër 20,	20c. Lo	cation - City or	Town, State
Ĕ	Pages ment of i		4 Donation 5 Other (Specify)	moval from State			Cremator		200	5	Bet	thesda,	Maryland
Daltimore	permit. Pages Department of I Important: If It eny injury or o		21. Signature of Funeral Service License	. /	101173	Rot 300	Name and Accept A.  Name and Accept A.  Name and Accept A.	dress of Fac Pumphre	y Fune	ral Hom	e, Ro	ckville, MD 208	Inc.
7			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one									, 12 200	Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition resulting in death)	Uremio	Coma	l							Onset and Death
	/Medical Examiner		1	Due to (or as									
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Ś	ate be executed hysician and the buriat-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as	a conseque	ence of):							
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Ď	tiffical og phy as th												
C. DOX	w requires that the death certificate be executed to be not signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal o	leath 3 🗆	Ectopic pregni Other (s <i>pecif</i> )				2	23d. Date of deli Month	ivery Day Year
	that til ed by detac		Part II. Other significant conditions conf	nbuting to death b	ut not result	ting in the un	derlying cause	given in Par	rt I.	23e. Did t	obacco u	se contribute to	the cause of death?
cords,	law requires that the as been signed by th 2 should be detache	ted by	Advanced Alzheime									_	obebly 4 DUnknown
υ Γ	The faw ate has by page 2 st	Completed								24a. Was auto perfo	psy ormed?	24b. Were au prior to death?	topsy findings available completion of cause of
NI G	ian: rtifica ctor, p	BeC	25. Was case referred to medical					26. Pla	ce of Death	(Check only			
	Physician: r this certific ral director,	70	examiner? 1 ☐ Yes 2 🛣 No	ospitaf: 1 🗆 Inpatie	nt 2 🗆 E	R/Outpatient	3□ DOA	Other: 4 🗆 I	Nursing Hom	ne 5 ☐ Resi	dence 6	6 <b>X</b> Other (Spec	onyHospice
5	ng Pt fter th	:uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	ry Year) 2	28b. Time of Injury	28c. l	njury at Work?	2	8d. Describe	how injury	y occurred	
SIOI	Attending ir death. ector: After by the funer	cati	2 Accident investigation					1  Yes 2 [	□No	_			
	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubus	ury - At hom c. <i>(Specify)</i>	ne, farm, stre	eet, factory, off	ice	2	8t. Location ( City or To			ral Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	cian: To the best er: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at the estigation, in r	e time, date ny opinion, d	and place, a eath occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	20				ense numbe	1.5		29d. Date	e signed (Monti	n, Day, Year)
		>	(Color)	/re		-W	70	412	18		12	119/0	2,
i	/		30. Name and address of person who cor	npleted cause of d	eath (Item 2	23a) (Type, I	Print)					11	,,

State Registrar

Charles Harrison, M.D.
31. Date filed (Month, Day, Year) 32



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Year

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DEC 2 1

2005

32 Registrar's Signature

Amend item#5, perInf C850, 12-28-05 The Mark Indelible Ink. Assure All Copies Are Legible.

Amend item#5, perInf C850, 12-28-05 The Mark Item#5, perInf C850, 12/29/05

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey
DECEMBER 18 **Physician** JOSEPH KOVAC R. 2005 7:00am /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner BEL AIR HARFORD LORIEN BEL AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
JULY 2, 1919
NEW YORK 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1⊠ M 2□ F Yrs. 86 Director Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2 No MD HARFORD BEL AIR Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1909 EMMORTON ROAD 21015 USA Funeral 12. Was Decedent Ever in U,S. Arrued Forces? 1 ☑Yes 2 ☐ No If Yes, Give 17,1747 T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE Baltimore, Maryland 21215-0020 δ 3 Widowed 4 □ Divorced II WW Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mentel Hygiene. merked other ther PLUMBER PLUMBING 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KOVAC STEPHEN ELIZABETH KANZIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN M. KOVAC / SON 2425 DIXIE LANE f Haalth FOREST HILL, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any injury or once. METRO CREMATORY 12/19/05 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE BALTO, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA END STAGE Examiner Due to (or es a consequence of): Examine The law requires that the deeth certificata be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) physician s tha burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) for use es ΘS Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Vunknown 1 Yes 2 No CONGESTIVE HEART þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? certificate has been s ractor, page 2 should Completed OBSTRUCTIVE LUNG DISEASE completion of cause of death? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? the funeral diractor Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6 X Other (Specify) ASSISTED 1 Yes 2 No Medical Certification: To After this 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Directo complataly filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital (actifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month. Dav. Yeer) 29b. Signature and title of certifier, Mickey MD D45344 12/18/2005 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 622 S. UNION AVE, HAYRE DE GRAVE MO 21078 SURESH DHANJANI, MO 31. Dete filed (Month Pay: Year) 1 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 1:20PM **Physician** Robert December Paul Kempa 2005 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale or I Year If Under 24 Hrs Center Baltimore Square Hospital ranklin Social Security Number 6 Sax 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X** M 2□ F 61 Yrs 218-42-2299 Director October 17,1944 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 28a-f ahow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1739 Drexel Road 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 【XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed....h and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ 9 years Bethlehem Steel Krimper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Kempa Josephine Janowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i 1739 Drexel Road, Dundalk, Md. 21222 Ivadell Kempa wi fe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December permit. Pages Department of I Important: If it any injury or o 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 21, 2005 Bayview Crematory Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Fundral Service License 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease Physician a Atherosclerotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA SIL After the funeral of 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the normal safter death.

To the Funeral Director: Af death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Munor, MD 00061852 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Junathan R. Murrow MD. 9000 Franklin Square prive, Baltimore, Mb. 21237 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 3 per doc 8512 1-17-06 vv
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 2005 **Physician** LLoyd Charles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care-Charles Village 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**¥**] M 2□ F Days Hours Months Min. Yrs. Director 220-30-0047
Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at XXYes 2 □ No Director Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA permit. Pages 1 and 2 should be tiled within 72 hours after death v
Department of Health and Mental Hygiene
Important: If Item 271s marked other than "natural", or Items 23a
any Injury or other traumatic event, the Medical Examples reserved. 1931 N. Aisquith Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Bus Driver 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adams Viola Lloyd, Sr. Charles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 N. Aisquith Street, Baltimore, Md. 21218 Wife Barbara Lloyd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 12-21-05 Randallstown, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licens e Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Coath the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exacts) Examiner use as the burial-transit The law requires that the death certificate be executed en that initiated events and resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No 1 Yes 2 7 M 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Death
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. 1 □ Yes 2 □ No investigation Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L o the Hospital 29a. Certifier 1 beertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe December 21,2005 00 6050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimor Danl

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2005

ORIGINAL

32. Registrar's Signature

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			of Maryland / Depa Ce		lealth and M	•	enn5	41120
Physicia /Medic			oard			Date of Death  Month  Ecom ber		
Examin	er	4a. Facility Name (If not institution, give street and a Doctors Hospital	number)	Lanham	Location of Death	4	c. County of Deal	
Funeral Director		5. Social Security Number 6. Sex 244-38-1391 1 M 2 St F	7. Age (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Bird Co Nor	hplace (State or Foreign buntry) th Carolina
Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Georges	10c. City, Town or Lo					10d. Inside City Limits 1∑Yes 2 □ No
with the ta or 286 I be not	Director	10e. Street and Number 7601 Riverdale Rd. #43	Q	10f. Zip Code 2078	4	10g. (	Citizen of What Co	ountry?
within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show the Modical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 1 □ Ye  If Yes.	ecedent Ever in U.S. 13. Forces?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	USA  14. Race - Ame Black, Whit	
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2 shou and M le mar raumat	-	19a. Informant's Name/Relationship (Type, Print)			and Number or Rur	al Route Number, City		
ages 1 and nt of Health :: If item 27		James Laboard/Husband  20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fro	20b. Place of Dispo cemetery, cre	Riverda1 osition (Name of matory or other place	ө)	Date 20c.	Location - City or	
permit. Pa Departmer Important any injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	. 10 M	National Name and Address Name and Address National National National National	ss of Facility Funeral	3-2005 La Home, Inc Washingto	urel, MD	
Physician and Imperior and Physician and Phy	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c.	to (or as a consequence of):  to (or as a consequence of):		17954			Approximate Interval Between Onset and Death
The law requires that the death certificate to the has been signed by the ettending physicage 2 should be detached for use as the it.	Physician/Medi	in the past 12 months?	egnant at time of death 5[	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
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To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4   Homicide Solomines bu	ace of Injury - At home, farm, st ilding, etc. (Specify)			28t. Location (Street City or Town, Sta	nte)	
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A		3 me and address of perso, who completed compl		Print) 16 Au Su	ute 2400	, Piverd	all, Ma	nyland 273
Sta Registr		31. Date filed (Month, Day, Year) 32 DEC 2 1 2005	Registrar's Signature	Courte				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 16,2005 /Medical County of Death Eacility Name (If not institution, give street and number) 4b. City Town, or Location of Death **Examiner** ratons VIII sina altimore Home 8. Date of Birth (Month, Day, Year) 02-07-1930 7. Age (In yrs. last birthday) Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 212-44-9657 75 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Medical Exercities at 1 ☐ Yes 2 ☑ No MD Elkridge Howard Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6150 Hooks Lane 21075 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Iten any righty or other traumatic event, Ite Medical Exert. 1 Never Married XXMarried American Baltimore, Maryland 21215-0036 1 Yes 2XXXVo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harlan Handy Mattie Wheatley 2 19a. Informant's Name/Relationship (*Type, Print*) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila K. Montgomery/daughter 6150 Hooks Lane Elkridge MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 12-20-2005 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 8 signed by 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 24 No 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Pl
 24 hours after death.
 Funerel Director: After th Certification; After I Natural 5 Pending 1 🗌 Yes investigation 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 29a. Certifie 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the I 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filod (Month, Day, Year)

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMI

32. Registrar Signature

		·	For State Registrar		State of	Marylar	-			Health and Death	Mental H	ygiene Reg. No	OOF	OFFICE AND ADDRESS OF THE ADDRESS OF	22
	DI.		Decedent's Nam	e (First, Middle, L	.ast)						2. Date of D	Death Da	y Year		of Death
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0.	Examin	_		^	ive street and numb	oer)		4b. City	y, Town, o	or Location of Deat	h	40	County of Dea		
			6317		Heights	Ave		139	er 1 Year	If Under 24 Hrs	11) 212	_	Balhn		ity
75	Funeral Director		5. Social Security N 353-05-6		Sex 1 M 2 X F	. Age ( <i>in yr</i> s. 85	(ast birthday) Yrs.	Months		Hours Min.	8. Date of 8 (Month 24)	inth Pay dear	9. Bi	rthplace (Stat country)	e or Foreign
r p <sup>*</sup>	V		Usual Residence o		^						00/24/	1520		1 L	•
	yland		10a. State	10b. County		10c. Ci	ty, Town or Loc	ation						10d. Inside	City Limits
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Z	er de Item	nue	11. Marital Status	ded OO Marka	12. Was Deced	es?	I.S. 13. W	/as Deci Yes, sp	edent of hearing Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or h to Rican, etc.)	No-	14. Race - Am Black, Wh	ite, etc.	
RM/	irs aft	by F	3 ₩ Widowed	ried 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat		1	☐ Yes	2 No	Specify:			Specify:	WHITE	
E LEADERMAN 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or iteme 23a or 28a-f show to other than "natural", or iteme 23a or 28a-f show event, it is Medical Examinat must be notified at	Be Completed by Funeral Director		15. Decedent's	Education		16a. Decede	ent's Us	ual Occur	pation		16b. H	(ind of Business	s/Industry	
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Se Z	should ind Men imarke umatic	٩	JAC0B_				BILIACK			ANNA				IULMAN	
BE RUTH	ges 1 and 2 should it of Health and Mer it liem 27 is marke or other traumatic		19a. Informant's N				1			and Number or Ri					
	s 1 and if Healt item 2 other	1	DEBRA KO		AUGHTER	20b. F				COURT -	Date VA	_	ocation - City o		
Tou	nt of nt of t: H is		1 Burial 2	☐Cremation 3	□Removal from St	ale	Place of Dispos cemetery, crem								
SAID TO Baltimore,	permit. Page Department of Important: If any injury or once.	1	4 Donation 21. Signature	5 Other (Spec		SHA	ARI TFI			is.   12/2 ess of FacilitySOL	20/2005	NOOM	DLAWN,	MD	
S	Depa impo eny ii			10						ERSTOWN F					08
			23a. Part1. Enter	the disease, or co	mplications that cau ly one cause on eac	sed the deat							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approxim	nate
	Physician		Immediate Cause	(Final	/3					Failsne				Onset an	
	/Medical		disease or condition resulting in death)	4	Due to (or	Ses+	uence of):	L 0 (	'1	ra 113 / C					
	Examiner		Scarontially list of	ondfficere		hemi		re	lion	ny o pat	hy				
	D =	ner	Sequentially list of if any, leading to in cause. Enter Under Cause (Disease or	mmediate arlying		ras a consec	quence of):								
	and trans	Examiner	Cause (Disease or that initiated events resulting in death)	S	c. Com	≥ ∩ ⊂ C	7 4	-	er	Dise	ase_				
760,	ate be executed hysicien and the buriat-transit		resenting in coatin	Lust	1000		T Dis	. 1	Lac	Dise Mellih	4				
	physic the t	dicai			d. 74#			1 2 S	+63	mellin	'S				
Division of Vital Records, P.O. Box 68	uires thet the death certifical signed by the ettending phid be detached for use as the	Physician/Med	IF FEMALE:		23c. If yes, outco	me of prean	ancv						22d Date of de		
B	etter for u	ciar	23b. Was decedent in the past 12 1 Tes 2	months?	1 ☐ Live birt	h 2⊡Feta ntattime of d	al death 3 □ E	Ectopic (	pregnancy	У			23d. Date of de Month	Day	Year
o.	the c	hysi	9 ☐ Unknown		9□ Unknow	m			. ,, -						
<u>ب</u>	Physician: The law requires thet the this certificate has been signed by the rail director, page 2 should be detached.	by P	Part II. Other signi	ficant conditions	contributing to dea	th but not res	sulting in the un	derlying	cause giv	ren in Part I.	23e. Did	l tobacco	use contribute t	o the cause o	if death?
rd	w require been sig should b										1 🗆	Yes 2	<b>№</b> 3 🗆 Р	robably 4 (	⊒Unknown
SCO	aw requisits been 2 should	Completed									24a. Wa			utopsy finding	
Œ.	The I	E									per	opsy formed? 2 <b>√</b> No	death?	completion of	cause or
ita	sian: artifica ctor.	Be	25. Was case refer	rred to medical						26. Place of Dea					
<u>~</u>	hysic his ce I dire	2	1 Yes 2	No	Hospital: 1 🗆 Ing		ER/Outpatient	3 🗆 D	OA Ott	er: 4 ☐ Nursing H	lome 5.2 Re	sidence	6 ☐Other (Spe	ecify)	
Ē	ing P	ë.	27. Manner of Deat	th 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injui Wor	ry at rk?	28d. Oescribe	how inju	ry occurred		
<u>s</u> ;	Attending ir death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide	investigat 6 □ Could not	he			М		Yes 2 □No		1.			
Σ	or At after of Direct in by	Certification;	4 Homicide	determine	286. Place o	f Injury - At h g, etc. <i>(Specii</i>	ome, farm, stre fy)	et, facto	ry, office		28f. Location City or To	(Street ar own, State	nd Number or R e)	ural Route N	ımber,
	ours and merei		29a. Certifier	f© Certifying I	hysicien: To the b	est of my kn	owledge death	OCCUPEN	d at the tu	me date and place	and due to th	0.001100/0	\		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only one)	∠ Medical Ex	aminer: On the bas	is of examina	ation and/or inve	estigatio	n, in my c	ppinion, death occu	irred at the time	e cause(s e, date an	d place, and du	s stated. e to the cause	∌(s)
_	To the within To the comple	Me	29b. Signature and	title of certifier				29	9c. Licens	se number		29d. Da	te signed (Mon	th, Day, Year	)
		2	· M.	A < 0.1	A.	~		1	D4:	5811		12	-19-	05	
	0	1	30. Name and addi	ress of person wh	o complet suse	of death (Iter	n 23a) (Type, P								
_/,			6535	- Nor	th Cha		Steet	7 3	Silte	2 400 N	5 10	ر ا	N M	0 21	204
	Sta Registra		31. Date filed (Mor	DEC 2	2 2005 32. P	istrar's Signa	ature f.	05							

			For State Registrar	State o	of Marylar		rtment of H		Mental Hy	giene Reg. No.	05 4	1123
			Decedent's Name (First, Min	ddle, Last)					2. Date of D	eath		3. Time of Death
	Physici /Medio		Dorothy	H. Meeki	ns				Decem	ber 19	, 2005	2:38P M
	Examir		4a. Facility Name (If not institu	tion, give street and nu	ımber)		4b. City, Town, o	or Location of De			nty of Death	
			Carroll	Hospita1	Cente	r		inster		Ca	rroll	
	Funeral Director		5. Social Security Number 217-20-0287	6. Søx 1□ M <b>X</b> XF	7. Age (In yrs. 81	last birthday) Yrs.	Months Days	Hours Mi	n. (Month, D	irth Pay, Year) <b>7,</b> 1924	l Count	
	and **		Usual Residence of Decedent 10a, State 10b, Cou		10c, Ci	ity, Town or Loc	ation				10	d. Inside City Limits
	Manyis f sho	ō	MD Bal	timore		Owings						1 □ Yes <b>¾</b> □ <b>X</b> No
	the 286-	Director	10e. Street and Number				10f, Zip Code			10g, Citizen	of What Count	
	3a or		17 St. Th	nomas Lan	e			117			S.A.	
	er deat	Funeral	11. Marital Status	Amed F		J.S. 13. W	as Decedent of F Yes, specify Cub	lispanic Origin? an, Mexican, Pue	(Specify Yes or Narto Rican, etc.)		Race - America Black, White, e	
036	urs afte	by	1 Never Married 2 Never Marrie	If Voc Ci	XXNo ive Dates:	1	□ Yes 🗶 🕱 No	Specify:		Spe	cify: Whi	te
15-0	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "naturel", or Itams 23a or 28e-1 show event, in e Medical Exercities in instite incitifical at	Completed	(Specify only hig	dent's Education thest grade completed)		16a. Decede	ent's Usual Occup ind of work done O NOT use retire	pation during most of w	rorking	16b. Kind of	f Business/Indi	ustry
12		dwo	Elementary/Secondary (0-12	2) College (	(1-4or 5+)		Homemak	•		Owr	n Home	
<u>Q</u>	Hygi other ent, I	Be C	17. Father's Name (First, Midd	lle, Last)					ame (First, Middle			
lan	should be and Mental le marked o	To B	Robert F1	oyd Harmo	on			Dais	y Mari	e Mich	nael	
Maryland 21215-0036	es 1 and 2 should be filed of Health and Mental Hygi f item 27 ie markad other r othar freumatic event, I		19a. Informant's Name/Relation		aughte				- Ru <i>ral Route Numl</i> Finksh	-		
ē,	s 1 ar f Hea item othar		20a. Method of Disposition		20b.	Place of Disposi	ition (Name of	- 1	Date		n - City or Tow	
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		XX Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other				View	12	/23/05	Syke	sville	a. MD
alti	permit. Departm Importa any inju		21. Signature of Funeral Serv	ice Licenses	Me	morial	Name and Addre					pel P.A.
m	89 1 8		Thekend	1 Teure		11	605 Rei	sterst	own Rd.	Owing	s Mill	s,MD2111
			23a. Part1. Enter the disease shock, or heart failure. I	, or complications that list only one cause on	caused the dea each line.	th. Do not enter	r the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	ر مک	otes							Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
В	LAMITHE	Ļ	Sequentially list conditions,	b. Due to	(or as a consec							
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (2) season in jury that initiated events	<b>₹</b>	(or as a consec	quence on:						
	icate be axecuted physician and s the burial-transit	Examine	that initiated events resulting in death) Last	c	(or as a consec	quence of):						
8760,	e be a	dicai I										
9	tificat g phy as th	ledi	- management									
Вох	requiras that the death cartificate be axecuted aan signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		Ectopic pregnancy	ı			Date of deliver	
	ne dea the att	sici	in the past 12 months? 1 □ Yes 2 ☑ No		nant at time of o		Other (specify)				Month D	Day Year
P.O.	that the de ed by the detached	Phy	9 ☐ Unknown  Part II. Other significant cond	litions contributing to s	looth but not ro	culting in the use	fashina anuna au	on in Dort I	22a Did	tabassa usa se	antributa ta tha	cause of death?
	iras tha signed f be dei		Fair 1 C Laws	Reval	abati but not iba	sulling in the und	serrying cause giv	ren in Parti.		Yes 2 No		bly 4 Dunknown
orc	v requir baan s should	etec	- Stage	1/c eact	Citaeca							
Vital Records,	e tav has	Completed by							24a. Was	s an 248 opsy ormed?	prior to com death?	sy findings available pletion of cause of
a	i <b>cian</b> : The t certificate ha rector, page		OF Was seen referred to made	lical .					1 Tes	2 No	1 ☐ Yes 2	No
S	nding Physician: th. : After this certifica s funeral director, p	o Be	25. Was case referred to med examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3□ DOA Oth	O.C.	eath (Check only Home 5 - Res		Othor (Canaile)	
10	g Phy er this	-	27. Manner of Death	28a. Date	of Injury ofth, Day Year)	28b. Time of	28c, Injur	y at		how injury occ		
ion	Attending r death. sctor: After by the fune	atio	1 ☑Natural 5 ☐ Per 2 ☐ Accident inve	nding (1910) estigation	iiii, Day 1 Gai)	Injury	M 1 🗆	Yes 2 □ No				
Division of	of or Attendated after death	Certification:		uld not be emined 28e. Place build	e of Injury - At h ling, etc. (Speci	ome, farm, stree fy)	et, factory, office		28f. Location City or To	(Street and Nui wn, State)	mber or Rural i	Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl to the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certification (Check only one)	fying Physicien: To the cel Exeminer: On the band man	e best of my kno casis of examina oner stated.	owledge, death o ation and/or inve	occurred at the tirestigation, in my o	me, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and date and place	manner as sta e, and due to t	ted. he cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of cert			<del>-</del>	29c. Licens	e number		29d. Date sign	ned (Month, Da	ay, Year)
	->-0		m. N	USIV 1	no		735	711		12/19	112005	-
Q.	/>/		30. Name and address of pers	on who completed cau	se of death (Iter	m 23a) (Type, P						
O	1:=".		Moku ter	Nasin 1	10.9	oy Wa	, houghou	Rd, S	vile D.	Westin	inster.	nD 21157
	Sta		31. Date filed (Month, Day, Ye	ar) 32. F	Registrar's Signi		J			-		
	Registi		nre	2 1 2005	Thoras a	K A	estel					
DH	MH 17 Rev 1/2	001	to inco		a silection again.	ORIGINAL						
						JIIIGINAL	-					

DHMH 17 Rev 1/2001

Mclean, Kevin 12/8/00

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day P **Physician** M.LLER RENDA /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) Examiner 707 Maiden Choice Lane Room 8212 Catonsville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Director 016-12-5676 Jan. 1, 1921 Maine Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 23a or 28a-f ahow any lujury or other traumatic event, the Medical Examiner must be notified an enter. 1 ☐ Yes 2 ☑ No Funeral Director Baltimor e Catonsville Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 707 Maiden Choice Lane Rm8212 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Yeer or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Scott Miller 9405 Parsley Drive; Ellicott City, MD 21042 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State Crest Lawn Mem. Gardens 12/22/05 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Fundam Service Licenses 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. M01290 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner Concerney En Gola or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Artery attanding physician Division of Vital Records, P.O. Box 68760. Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Certification: To 1 Yes 2 No this erai Director: After thi filled in by tha funeral 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 1 Natural 5 Pending r death. 1 TYes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completaly filled in by 4 - Homicide Medical Certifying Physician: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. r. In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 2 Medical Exar one) 29b. Signature and title of certifie 29c. License number 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) ATURENT Play Colenbury 11058 Lottle1 JERRY. no 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Day December 16, Mary Miller 2005 7:00 P M 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 340 S. Oldham Street Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/16/2005 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖸 F 217-24-5380 77 Yrs West Virginia Usual Residence of Decedent 10b County 10c, City, Town or Location 10a State 10d. Inside City Limits 1 ☐Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 340 S. Oldham Street 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZZNo ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Tyes 2 TXNo Specify: Specify: 3 → Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant State 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nicholas Baouris Zaharoulo Kasiotis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Kazas/Son 8736 Trent Road Richmond VA. 23235 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Greek Orthodox Cem. 12/20/05 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licenses 6224 Belair Road Baltimore, Maryland 21224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only a cau ch line. fmmediate Cause (Final Ca 7 disease or condition resulting in death) Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify)

Priysician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f ehow

or Itame 23a death v

permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 le marked other then "natural", or Itam eny injury or other traumatic event, It is Madical Examples once.

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

MD

other traumatic event, the Madical Examiner roust be notified at

with the Maryland

Examiner certificate be executed use as the burial-transit the attending physician and Physician/Medical for detached signed by δ pe Completed certificate has Physicien: Be ျှ this funeral Certification: After death. Director: after Medical

68760 Box ( P.O. Division of Vital Records, Hospitel or Attending 24 hours a within 2 the er

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 27. Manner of Death

examiner'

1 🗌 Yes

Natural

2 Accident

4 Homicide

3 Suicide

25

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signalure and title of certifier Cz 30/Name and address of au

investigation

6 Could not be determined

2 ER/Outpatient

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

1 🗌 Yes

3□ DOA

29d. Date signed (Month Day, Year) 01

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 No

1 ☐ Yes

25

ome 5 lesidence 6 Other (Specify)
28d. les ribe how injury occurred

24a. Was an

1 🗌 Yes

26. Place of Death (Check only one)

4 ☐ Nursing Home

person who completed caus If death (ftem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year,

Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State

		For State Registrar	State of	Marylan		artmen <i>tificat</i>			and M	_	giene Reg. No.	05	41127
* # 1	19	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Day	Year	3. Time of Death
- Physi	ician dical	IOSANN IONN Warti	ni, Sr.							12_	14	2005	03:07 <sup>p м</sup>
Exan		4a. Facility Name (If not institution, give		er)				Location of				ty of Death	1
		Manor Care Rossvi					SVil.	le, M				timor	
- Funera		5. Social Security Number 6. Sr 218-07-0317	9X 7. DXM 2□F	Age (In yrs.)	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)		nplace (State or Foreign untry)
Directo	or	Usual Residence of Decedent		05	9					01/31	/1916	⊥Ma	ryland
yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
Man I-f sh	ţ	MD n/a		Ba1	timore								1 XYes 2 No
h the	ie	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Co	untry?
death with the Maryland me 23s or 28s-f show roust be notified at	Funeral Director	424 Hornel Stree	t			2:	1224				U.S.A		
r dea	ner	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	14. Ra	ace - Amer ack, White	ican Indian, , etc.
S afte	by Fu	1 □ Never Married 2 □ Married	1 X Yes 2 If Yes, Give			1 ☐ Yes					Spec	T 7	hite
13-UU30 72 hours after death with the Marylan naturel; or iteme 23a or 28a-f show fideal Evantinar must be notified at			Year or Date	es:	16a. Deced	font's Heur	AL Occupa	ation			16b. Kind of	Business	ndueto
	Completed	(Specify only highest gra	de completed)		(Give	kind of wo	rk done d	lurina mosi	t of workii	ng	TOD. KING OF	20211622/1	ndustry
d within giene.	E	Elementary/Secondary (0-12)	College (1-4	or 5+)	cler	ical					govern	mont	
o filed with Hygiene.	0	17. Father's Name (First, Middle, Last)			CICI	1001		18. Mothe	r's Name	(First, Middle	Maiden Suma		
VIBICO VIDENCE TO VIDENCE TO VIDENCE V	To B	Pasquale Martini						Santa	a Unl	cnown			
L čnác	-	19a. Informant's Name/Relationship (7	Гурө, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or Rura	Route Numb	er, City or Tow	n, State, Z	ip Code)
and 2 st and 2 st ealth and m 27 ts r		Nancy Preston, Da	ughter		5812	Corpo	ral	Jones	s Ct.	., Mt.	Airy, M	ID 21	771
or Head	Č.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from St	_	Place of Dispo semetery, crer	sition (Nari	ne of ther place	θ)	D	ate	20c. Location	- City or T	Town, State
Pag nent ant: fi		4 Donation 5 Other (Specify			11y Hi	11 Me	mori	al 🖁	12/1	7/2005	Midd1	e Riv	er. MD
baltimore permit. Pages to Department of Infortant: If ite mportant: If ite my injury or ot	once.	21. Signature of Funeral Service Licen	500		22	. Name an	d Addres	s of Facilit	h.e				lto. MD
n gaes	ä	1/mg			Ch	arles	s S.	Zeile	er &	Son, I	nc.		21224
		23a. Part1. Enter the disease, or company shock, or heart sides. List only	one cause on e	ised the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition	a	HY	POXI	A							Onset and Death
/Medica Examine		resulting in death)	Due to (or	as a conseq	uence of):	.0.1	10	0	u -	7	·		
LAdmine		Sequentially list conditions.	b. Due to /or	as a conseq		スプ	ME	100	٠ .	DISEA	36		
pe tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01	as a conseq	derice or).								
be executed ician and burial-transit	Xan	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):								
	cai		d										
X 68/ certificate oding phys			. u.										
BOX 68  Beath certifica attending ph	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			35					23d. D	ate of deliv	very
. 0 0 0	cia	in the past 12 months? 1 □ Yes 2 □ No		h 2∏Feta nt at time of d		Ectopic pr Other (sp					N	fonth	Day Year
et the though the stacke	Physician/Med	9 □ Unknown	9LI UNKNOW	m									
	by 6						ause give	en in Part I.				-	the cause of death?
ecords, law requires t as been signe			< > 7	7676	5011	A				1 🗆	Yes 2⊡No	3 🗌 Pro	bably 4 Unknown
2 8 0	pie									24a. Was	osy	prior to c	opsy findings available ompletion of cause of
The The page	Completed									perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 □ No
DIVISION Of VITAL Pror Attending Physician: The titer death.  Director: Atter this certificate in by the funeral director, pag	Be (	25. Was case referred to medical							of Death	(Check only o	one)		
Of Physic rthis cural dire	2		Hospital: 1 □ Inp		ER/Outpatier			4 52 140			dence 6 🗆 O		ify)
JING F	0	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury occu	rred	
DIVISION I or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be		f Injune - At h	ome, farm, str	M factor		Yes 2 □		28f Location /	Street and Num	her or Ru	ral Route Number.
DIVISION Attended after death I Director:	ertif	4 ☐ Homicide determined	building	, etc. (Specif	(y)	eet, ractory	, once			City or To		DOT 01 1101	ar riodio radilibor,
Hospitel Hospitel Hospitel Funers Funers Tely filled	Ö	29a. Certifier 1 Certifying Ph	ysician: To the h	est of my kno	wiedge, deat	n occurred	at the tim	ne, date an	d place a	and due to the	cause(s) and n	nanner as	stated.
To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	edicai	(Check only 2 Medical Exam		is of examina									
To the within 2 To the complet	2	29b. Signature and title ol certifier						number			29d. Date sign		
		DED . "	10			1	05	530	6		DEC. 15	J. W.	2005
1,		30. Name and address of person who	completed cause	of death (Iten	n 23a) (Type,	Print)		_	. ,		)		21237
_ 4		DENNIS . HODI	E 910	6 PHIC	mel	PHA	RD	2 4	1156	Sook	BALTO	ND	21237
1000	State istrar	55000000		gistrar's Signa	ture	NED .							ı

		•	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate			Mental Hy	giene Reg. No.	005	41128
	Dhysiai	20	1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Media		JOSEPH		OLI				DECEMBI	ER 17	2005	3:14 A M
	Examir	ner	4a. Fecility Name (If not institution, give		IDICT	4b. City, T		cation of Dea	ıth	4c. Cou	unty of Death	
	Euroval	224,-	HOSPICE OF BALTI  5. Social Security Number 6. S		TKISI (In yrs. last birthday)	If Under 1		f Under 24 Hr	s. 8. Date of Bir	th		I MORE
7%	Funeral Director			X M 2 F 83		Months	Days	Hours Mir	8. Date of Bir (Month, Da 06/13/	1922	Col	place (State or Foreign intry)
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	nantine.						10d Inside Circlinia
	Maryla f shov	or	MD N/A		BALTIMO							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	\	DALITHO	10f. Zip (	Code			10g. Citizen	of What Cou	intry?
	th with	a D	7109 BOXFORD ROA	\D		212	15				U.S.A	•
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Musical Exemination unit be notified at	by Funeral	11. Marital Status  1 Never Married 2 N Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:		Was Decede If Yes, specif	y Cuban, V	anic Origin? ( Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		Race - Amer Black, White ecify: WH	
5-0	72 h	etec	15. Decedent's Ec (Specify only highest gra		(Give	dent's Usual kind of work	done dur	on ing most of w	orki <b>ng</b>	16b. Kind o	of Business/li	ndustry
121	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	AGENT	DO NOT use	retirea)			TNSI	URANCE	
9	Hygie other	0	17. Father's Name (First, Middle, Last)		NOCITI		18	3. Mother's Na	ame (First, Middle			
Maryland	should be ind Mental imarked o	To B	SAMUEL		0L	INER		LYDIA		В	UCKNEF	}
Mar	id 2 sho lith and 27 is m	N	19a. Informant's Name/Relationship						Rural Route Numb			p Code)
	s 1 and of Health Itam 27 other to		SHIRLEY OLINER / 20a. Method of Disposition	WIFE	20b. Place of Dispe	osition (Name	of	JAU – I	BALTIMORE Date	-	<u> </u>	own, State
mol	Pages nent of int: If It		1 Burial 2 Cremation 3 C		B'NAI IS	RAEL C	ONG.	12/	20/2005	BALTI	MORÉ,	MD
Baltimore,	permit. Pages 1 Department of H Important: If Its any injury or ot once.		21. Signature of Funeral Service Licen						DL LEVINS ROAD - F			
÷	* 50		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not en	ter the mode	of dying,	such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SNDS	TAGE	REN	AL	315	SASE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):							0
	*	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence oi):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. =								
ó	be executed sician end burial-transit	Еха	resulting in death) Last		a consequence of):							
8760	cate be ex shysician the buria	licai		d								
P.O. Box 6	ne death certifii the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the state of the sta	2 Fetal death 3	⊒Ectopic pred ☐ Other (spe				23d.	Date of deliv Month	very Day Year
	gned by	by Pr	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the u	inderlying car	use given	in Part I.	23e. Did t	obacco use o	contribute to	the cause of death?
rds	w requires been sign should be	ed b	arterosdente	Cardiova	sular c	liseas	د		10	Yes 2□N	o 3□Pro	bably 4 Unknown
Records,	ie law requ has been ge 2 shoul	Completed	dementra						24a. Was	osy	4b. Were aut	opsy findings available ompletion of cause of
<u>=</u>	: The cate h	Co							perfo	200 No	death?	2 🗆 No
of Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Other		eath Check only			Hasare
	Phys ar this aral di	H- 1	1 ☐ Yes 2 No 27. Manner of D ath	1 ☐ Inpatien 28a. Date of Injur (Month, Day			c. Injury at Work?		Home 5 ☐ Resi 28d. Describe		Other (Speci curred	by trospice
ion	ittending I death. ctor: After ; the funer	atio	Natural 5 Pending 2 Accident investigation		Year) Injury	м		s 2 No				
Division	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, farm, st	reet, factory,	office		28f. Location ( City or To	Street and No wn, State)	umber or Rui	al Route Number,
	pital ours a seral Diffiled i		29a, Certifier (Certifying Ph	ysician: To the best of	of my knowledge, deal	h occurred a	the time	date and plac	and due to the	031150/6) 300	I mannor as	stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination and/or in	vestigation, i	n my opin	ion, death oc	curred at the time,	date and pla	ce, and due	to the cause(s)
	To th withir To th comp	X	29b. Signature and title of certifier	00	^ ^	29c.	License n	umber		29d. Date si	gned (Month	Day, Year)
)	1		Kendale	1 Vace	lls	T	360	642		19/	17/	05
./	18	1	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print)	01.	S+/	Bcelto	MJ	2120	14
<b>E</b>	Sta	ate	31. Date filed (Month, Day, Year) DEC 2 2 2		ur's Signature	N Lh	and	01/	.00010	- 10	0101	/
	Regist		DEC 2 2 2	UU5	as the stage	A STORY						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MARY AGNES LEE PETERSON 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore I Year If Under 24 Hrs. Good Samariton
5. Social Security Number 6. Sex Hospital N/A

9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year)
July 23, 1 Funeral Hours Months 1 □ M 2 → F Yrs. Director 1924 Maryland 218-14-0191 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ortant: If itam 27 is markad othar than "natural", or itama 23a or 28a-f shov injury or othar traumatic evant, the Mcdical Examinar must be notified at 1 ☐ Yes 2 1 No Director **Baltimore** Maryland Baltimore County 10e. Street and Number 10g. Citizen of What Country? with Be Completed by Funeral 21239 USA 6623 Loch Hill Road death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "ne any injury or other fraumatic event, the Medis 2005. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ William Lee (Unknown) Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin A. Peterson (Husband) Toch Will Road, Baltimore, Maryland 21239
Date 20c. Location - City or Town, State 662.3 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulanev Valley Mem Grdns 12/23/2005 Timonium, Maryland 21. Signature of Function Service Licensee Mitchell-Wiedefeld Funeral Home, Inc.

Politimeral Maryland 21212 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or s a consequence of): disease or condition resulting in death) Previnoma /Medical Examiner Vasculi tis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed cardio my o the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical ast IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed certificate has

24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Maryland

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier weisman

H0059388

29d. Date signed (Month, Day, Year) 12-20-05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Bluch. Loch Kaven

31. Date filed (Month, Day, Year) 32. Registrar's DEC 2 1 2005

DHMH 17 Rev 1/2001

Registrar

or Attanding Physician:

funeral director,

filled in by

completely

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after death.

within 24 hours a To the Funeral D

Certification: To

Medicai

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 🗙 No

examiner?

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Mari

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Car1 Petersen December 2005 8:15p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sykesville Carroll 6137 Oak Hill Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**∑** M 2□ F 294-18-8367 Yrs. Ohio Director Usual Residence of Decedent State Md 10b. County 10c. City, Town or Location 10d. Inside City Limits Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Carroll Sykesville 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6137 Oak Hill Drive 21784 USA Pages 1 end 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 ☐XNo ρ Specify: white 3X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Administrator Social Security permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth, any Injury or other traumatic event, 90cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Simon Petersen Anni Elina Mattila 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Linda E. Wilson (Niece) 31 E. Pacemont Road Columbus, OH 43202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 12-17-05 Sykesville, Md 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Mosteratio ( ceoleras **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are ultimized devents). Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signer; page 2 should be d þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € N6 Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 HNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funerel Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the Hospital

Baltimore, Maryland 21215-0036

completely filled

aleet

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

URNES

32. Registrar's Signature

Sulte

			State of Mar State Pegistrar			of Health and M of Death		iene () (	)5	Section of the sectio	31
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	W	3. Time of	Death
	Physicia /Medic		Flora B.	Paoli_			Month Decembe	er 16,	<sub>Үваг</sub> 2005	5:24	Р
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or Location of Death		4c. County	of Death		
			Suburban Hospital	Un um land hinth da u	) If Under 1 \	Bethesda Year If Under 24 Hrs.	0. Date of Righ		lontgo		
	Funeral Director		1 □ M 2 🕅 F	In yrs. last birthday,		Pays Hours Min.	8. Date of Birth (Month, Day, June 10	Year)		ace (State o	ir Foreign
			185-16-0783 Usual Residence of Decedent	82 115.			June 10	, 1923		Ohio	
	nytand		10a. State 10b. County	0c. City, Town or L	ocation				10	d. Inside C	202
	Ba-f a	Director	Maryland Montgomery		1	Wheaton					2 X No
	with the	Dire	10e. Street and Number		10f. Zip Co		1	0g. Citizen of \		•	
	eeth	Funerai	4404 Bennion Road  11. Marital Status  12. Was Decedent Ev	er in U.S. 13.	Was Deceden	20906 t of Hispanic Origin? (Spi	acify Yes or No-		ted S	tates an Indian,	
(0	r iten	Fun	Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give			t of Hispanic Origin? (Spi Cuban, Mexican, Puerto	Rican, etc.)		ck, White, e	etc.	
93	ours a	by	3 Widowed 4 Divorced It Yes, Give Year or Dates:		1 ⊔ Yes 202	No Specify:		Specify		White	
21215-0036	within 72 hours after deeth with the Maryla jiene. r then "natural", or Items 23a or 28a-f shov the Medical Exertiner rouat be notified at	Completed	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>	(Give	dent's Usual C	done during most of work	ng	16b. Kind of Bi	usiness/Ind	ustry	
121	within ane. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)	III'e.	DO NOT use i	ŕ		TI		a i +	
d 2	Hygie Hygie other	e Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I		niver	SILY	
<u>a</u>	lid be lental rked c	To Be	Elv Bramson				Ida	Grodne	r		
Maryland	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural, or itema 23a or 28a-f ahow aumatic event, the Medical Exertiment han be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (S	treet and Number or Run	al Route Number	City or Town,	State, Zip	Code)	
	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked othe other traumatic event,		Giuseppe Paoli/ Husband			Bennion Road					
Baltimore,	Jes 1 t of Hi if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State	20b. Place of Disp cemetery, cre Montgo:	matory or other	r niace)	ember	20c. Location -	City or To	vn, State	
Ë	tment tant:		4 Donation 5 Other (Specify)	Cremat	orium T	nc. 18.	2005	Bethe	sda,	Mary1	and
Bal	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Licensee	WOODD F	ethesd	Address of Facility Rob a-Chevy Chas a, Mary land	ert A. I	7557 W	y Fun Viscor	eral Isin A	Home/ venue
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	M00335 F	ter the mode o	a,Mary Land of dying, such as cardiac	or respiratory arr	SUI		Approximation and the control of the	(8
	Physician		Immediate Cause (Final disease or condition	12 with	mi	70				Onset and	Death
	/Medical		reculting in death)	consequence of):	11100	<u> </u>				000/0	ing
	Examiner		Sequentially list conditions, b.								
€	ed sit	ine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	consequence off.							
0.	be executed sicien and burial-transit	хап	that initiated events	consequence of):					_		
250	e be e sicien s buria	sai E	4								
17	tificate ig phys as the	ledic									-
Вох	leath certifica attending pl	an/N	IF FEMALE: 23c. If yes, outcome of 1 □ Live birth 2		⊒Ectopic preg	nancy			te of delive	•	Vaar
). E	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	me of death 5	Other (speci	fy)		Mo	onth	Day 1	Year
P. P.	thet the		Part II. Other significant conditions contributing to death but	not resulting in the t	underlying cau:	se given in Part I.	23e. Did tol	pacco use cont	ribute to th	e cause of o	death?
)/{cds,	uires sign Ild be	d by	Inoracic Ac	Mic	Anei	Irysm	1 □ Ye	s 2 No	3 🗌 Proba	ably 4	Ünknown
ارکر ital Record	aw requir as been si 2 should	Completed				V	24a. Was a	n 24b. <sup>1</sup>	Were autop	sy findings	available
B	o <u>- g</u>	E O					autops perform	ned? 2.☑No	prior to con death? 1 □ Yes	sy findings apletion of c	ause of
ital		Be C	25. Was case referred to medical examiner?			26. Place of Deatl					
045	Physician: this certific ral director,	5	1 ☐ Yes 2 No Hospital: Inpatient				me 5 ☐ Reside			)	
on 0	Jing P	<u></u>	27. Manner of Death 1 √ Natural 5 ☐ Pending (Month, Day)	Year) 28b. Time (	of 28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occur	red		
A B. Division	Attending ir death.	licat	2 Accident investigation 3 Suicide 6 Could not be 28a. Place of Injur	y - At home, farm, si			28f. Location (St	reet and Numb	er or Rural	Route Num	1007
2 S	after Dire	Certification;	4 Homicide determined 288. Place of injur- building, etc.		,,,		City or Town	n, State)			
Flores	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of examiner: On the basis of examiner and manner state	xamination and/or in	th occurred at nvestigation, in	the time, date and place, my opinion, death occurr	and due to the cared at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s	s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 ~	29c. L	icense number	2	9d. Date signe	d (Month, I	Day, Year)	
	1/	}_	1 mendlend	le mi	2 [	) 3826	2	170	ec.	200	2
(	0		30. Name and address of person who completed cause of dea	RATT	Print)	101 Resea	re B	LVDI	uto	330	MO
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 1 2005	's Signature	de						

Type or Print in Black Indelible Ink. Example All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Paul Parakkal 0542PM December 16 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 
 Shady Grove Adventist Hospital

 ial Security Number
 6. Sex
 7. Age (În yrs. /ast birthday)
 Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Yrs Director 031-36-2310 July 21, 1931 India 74 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f ehow The Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Gaithersburg Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 57 Redding Ridge Drive 20878 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced <u>Asian</u> Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) National Institutes of 5+ Administration <u>Health</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Parakkal Mary Chembukkavu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 401 Ridgepoint Place Gaithersburg, Maryland 20878 Kalpana Parakkal/ Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State December 19, 2005 ö permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 19. Crematorium Inc. Bethesda, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/ethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Fufferal Service Licensee Bethesda-Chevy Chase, Inc. 75 Bethesda, Maryland 20814-3501 M00335 M00335 Bethesda, Maryland 20814-3501

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONDRY disease or condition resulting in death) MENASMASES 74RANS /Medical Due to (or as a consequence of): Examiner 2 YEARS HYROLO SOUNDWA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the use as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 2D No 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) stor: After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitat o within 24 hours aff To the Funeral Di completely filled in 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signaturand title of certifier 29c. License number 29d. Date signed (Month, Day, Year) msct DECEMBER 16 2005 MO 0000 57954 30. Name all address of person who completed cause of death (Item 23a) (Type, Print) SILADY CROWE ADVANTUT HOLPINAL NOCKULLE SAFY JOHN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

State Registrar 30. Name and address Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 2 1 2005

Balle AS. O

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

OCME

December 18, 2005

	CT		For State	State of Marylar		artment of F rtificate of			7111		41134
			Registrar  1. Decedent's Name (First, Middle, Las.	")	Cei	uncate of	Dealli	2. Date of De	Reg. No:		3. Time of Death
	Physicia		Aiyanna	L.		Rh	odes	Decembe	er 15,	2ŎÖ5	9:01 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Dea	th	4c. Count	y of Death	
	y		Harbor Hospital			Baltimon					
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	9. Birth	place (State or Foreign ntry) MD
			217-69-4641 Usuel Residence of Decedent					05 1	0 04		FID
	inylan show		10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits
	Be-f s	Director	MD NA	E	Baltim						1 X Yes 2 □ No
	with ti		10e. Street and Number	. A		10f. Zip Code	1225		10g. Citizen of	S.A.	-
	death ms 23	Funerai	2615 Carver Roa	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H		Specify Yes or No		ce - Ameri	can Indian,
2	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heath and Menth Hydene. I Heath and Menth Hydene. I them 27 Is marked other than "natural," or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Fur	X□XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		ir Yes, specify Cub. 1 □ Yes 2 <b>X</b> No	an, мехісап, Риеі Specify:	to Hican, etc.)	Speci	ack, White, <sup>(fy:</sup> B1	etc. .ack
5	2 hou satura		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	artin a	16b. Kind of E		
7	ithin 7 ne.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire N/A	d)	nkiiig	N/	′ <b>Δ</b>	
7	iled w Hygier ther ti	S	N/A  17. Father's Name (First, Middle, Last)	N/A		N/A	18. Mother's Na	me (First, Middle,			
<u>2</u>	td be lental ked o	To Be	Shan Rhodes				Brenda	White		,	
ai	should and Men a marke numatic	-	19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street			-		
 	1 and 2 Health em 27 I		Brenda White-Mo			Carver					
2	ges 1 it of H if Iten or oth		20a. Method of Disposition 1   Burial 2 ☐ Cremation 3 ☐	Removal from State		sition (Name of matory or other pla		Date	20c. Location	•	
	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Euneral Service Licen			morial		2/21/05	Randa	illst	own, Md
0	Departing Department of the police.		Vala V	narch	Ma 43	rch F/E	West ash Ave	, Balti	more,	Md	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a Asphyxia							
	Examiner		1	Due to (or as a conse		arca, ha					
		Jer	Sequentially list conditions, if any, leading to immediate	b. HSQUEDON  Due to (or as a conse	quence of):	eign obj	24				
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
00/00	icate be executed physiclen and s the burial-transit	a E	lesuting in death, cast	Due to (or as a conse	quence or):						
000		edicai		d							
X	death certifica attending pl d for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pregnanc	.,		23d. D	ate of deliv	ery
ם כ	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)	у		М	onth	Day Year
Ţ.	itcian: The law requires that the de certificate has been signed by the rector, page 2 should be detached		Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use cor	ntribute to t	he cause of death?
cords	quires en sigr uld be	ed by						10	Yes 2 No	3 ☐ Prof	babiy 4 □Unknown
ဝ	law reas bee	Completed						24a. Was		Were auto	opsy findings available ompletion of cause of
	The ate ha	Com						perfo 1 ☐ Yes	nrmed?	death?	2□ No
M	Physician: r this certific ral director,	Be	25. Was case referred to medicat examiner?	Hospital:	_	0**	200	eath (Check only o			
5	Physic this stal di	To :	1 XYes 2 □ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	11 3 DOA	4 🗆 Huising	Home 5 Resi			( <del>y</del> )
<u> </u>	Attending r death. •ctor: After by the fune	atior	1 □Natural 5 □ Pending 2 ☑Accident investigation		Injury 8:30		rk? ]Yes 23⊠No	subject o	hoked o	n ball	700
DIVISION	r Atta ter des irecto irecto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti	reet, factory, office		City or To	wn, State)		al Route Number,
2	pltal c		20a Cartifier		come	h annuard as the second		2615 C		1	howe, to
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	me, uate and plac opinion, death occ	urred at the time,	date and place	anner as s , and due t	o the cause(s)
	To the To the Complete	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date sign	ed (Month,	Day, Year)
			Jasha 37	eef MD		OCMI	£	I	December	r 16,	2005
2.	12		30. Name and address of person who	A 75-			Ctroct	Do1++			21 201
	Sta	te	Taska Z GVP 31. Date filed (Month, Day, Year)	32. Registrar's Sign		111 Penn	street,	DATULINO	re, Mar	yrand	Z1ZU1
	Registr		200		R	1. 10					

			For Amend Item   Stata Amend Item	State of Ma 17 per fh G	aryland 850 1	d / Depa 2-21-0	rtment	of H	ealth a	and Me	ntal Hy	giene	0.5	1135
	Physíci	an	Registrar  1. Decedent's Name (First, Middle, L     N	ast)							Date of Dea		Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g	100	lodical	Conter	4b. City, 1	Town, or	Location of		PCC.		y of Death	1110
	Funeral Director		5. Social Security Number () 6. 214-64-6284		e (In yrs. I. 41	ast birthday) . Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8	Date of Birt (Month, Da Aug. 2	h y, Year) 5.1964	Cou	place (State or Foreign ntry) vland
	<u>v</u>		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	he Man 28a-f sh	Director	Md. Baltimo	re		Reiste	rstow					10g. Citizen of	What Cou	1 ☐ Yes 2 ▼No
	23a or	ai Dir		ey Manor Rd	•		101. Zip	2113	36			U.	S.A.	
036	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Madical Examination at the notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Test 2 4 If Yes, Give Year or Dates:		l It	Vas Decede Yes, spec	rfy Cubar	spanic Ori n, Mexican Specify:	n, Puerto Ri	fy Yes or No can, etc.)	Bla	ce - Ameri ack, White,	
21215-0036	vithin 72 ho ne. han "natu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		5+)	16a. Deced (Give life. I Sale	kind of won OO NOT us	k doné d	urina mos	at of working		16b. Kind of 8		ndustry
2	is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, it a Me	Be	17. Father's Name (First, Middle, La			Dare	Oman					Maiden Suma		
Maryland	should and Men s marks	T <sub>0</sub>	19a. Informant's Name/Relationship						nd Numbe	er or Rural I		er, City or Town		
வி	Health tem 27 I		Diane Shires -  20a. Method of Disposition	Wife	20b. P	lace of Dispos	sition (Nam	ne of		Rd., .		rstown,		
Baltimore,	permit. Pages Department of t Important: If ite any injury or of		1X Burial 2 Cremation 3 4 Donation 5 Other (Spe	cify)		w Cath	edral	. Cen	n. D		2, 200	5 Balti	.more	
Ball	Departiment Important In any in any in ang i		21. Signature of Funeral Service Lic	lieud L	_		Eckha 11605	rut	rune	ral C	hapel,	P.A. Owings	Milla	21117 s. Md.
		2.5	23a. Part 1. Ent 1 the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	ne.	Do not ente	er the mode							Approximate Interval Between Onset any Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as		uence of):	13							2711
	6.4. X	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ									I WR
,092	eath certificate be executed ettending physician and for use as the burial-transit	ical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	uence of):								
Box 68	death certificat e ettending phy d for use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pre	egnancy					ate of deliv	- /
P.O. B	0 0	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown			Other (spe					М	onth	Day Year
	w requires that the been signed by th should be detache	ed by P	Part II. Other significant conditions	contributing to death between For		ulting in the ur	s+h	ause give	n in Part I	l. 		obacco use con Yes 2□No		the cause of death?
Division of Vital Records,	The law ate has b page 2 sl	Completed by Physician/Med	Hyportension								24a. Was autop perfo 1 \( \text{Yes} \)	an 24b. osy rmed? 2000	Were autoprior to codeath?	opsy findings available ompletion of cause of
f Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 Vo	Hospital: 1 1 patie		ER/Outpatien	t 3 🗆 🗅 O	Othe	) F		Check only o	one dence 6 □Ot	her (Speci	fy)
o uoi	After After		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Inju (Month, Da tion	ay Year)	28b. Time of Injury	M 2	8c. Injury Work 1 □ `	at ?? Yes 2□	1	d. Describe i	now injury occu	irred	
Divis	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin		jury - At ho tc. (Specif)	ome, farm, str	eet, factory	, office		28	f. Location (S City or To	Street and Num vn, State)	ber or Rur	al Route Number,
	Hospite 24 hours Funeral etely fille	edicai C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best camîner: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred a	at the tim , in my op	e, date an pinion, dea	nd place, an ath occurred	d due to the d at the time,	cause(s) and m date and place	nanner as : , and due !	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	11/11/11/11	M	1)	290	: License	76	7_		29d. Date sign	ed (Month,	Day, Year)
(	12		7-7 SAU	no completed cause of a	0 5	1	Print)	Tha	~ N	ND	212	31	1	
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	1 2005 Region	rar's Signa	ture								
100	5 5 7 M	-												

		·	1 - State Amend Item 12 Registrar		/land / Dep 50 12-24 <u>ē</u>	artment of tas	of Health and of Death			5 41136
	Physicia	an	1. Decedent's Name (First, Middle, Last	Harold	E. Sch	neider	Tr	2. Date of De Month	ber 15,2	Year 005 5:15 A <sup>M</sup>
	/Medic		4a. Fecility Name (If not institution, give		H. Den		wn, or Location of De		4c. County	
	Examin	ei	Stella Maris Hos			Ti	imonium		Ba	ltimore
	Funeral		Social Security Number     6. Se	x 7. Age (li	n yrs. last birthday	) If Under 1 Y Months D	rear If Under 24 H		rth ay, Year)	Birthplace (State or Foreign Country)
	Director		213-32-6616 Usual Residence of Decedent	69	Yrs.			Jan.2,		Maryland
	land ow		10a. State 10b. County	10	Dc. City, Town or L	ocation				10d. Inside City Limits
	Man B-feh	tor	Maryland Ba	ltimore			В	altimore	Co.	1 ☐ Yes 2XXNo
	ith the	Dire	10e. Street and Number			10f. Zip Co	ode 212	24	10g. Citizen of W	/hat Country?
:	within 72 hours after death with the Maryland igne. Igne. "natural", or Items 23e or 28e-f ehow the Madical Examiner must be nailfied at	Funeral Director	518 46th Street	12. Was Decedent Eve	ria II S 12	Was Decedes				d States
a.B	fter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No.	Alŗ		t of Hispanic Origin? Cuban, Mexican, Pu	erto Rican, etc.)	Blac	k, White, etc.
5:15 8	rai', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: G	ational uard	1 ☐ Yes 2 ☑	No Specify:		Specify.	White
5:	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece (Give	edent's Usual C e kind of work of	occupation done during most of w retired)	orking	16b. Kind of Bu	siness/Industry
5	within ene. than	duic	Elementary/Secondary (0-12)  12 Years	College (1-4or 5+)	me.	Gauger	енгеа)		Oil	Industry
2005	The Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	a, Maiden Sumam	
	should be ind Mental ind Mental or umarked o	To E	Harold E. Schne				Dorot	hy L. Ly	on	
15,	2 sho 2 sho 1s mark 1s mark		19a. Informant's Name/Relationship (7) Mrs. Yvonne R.		19b. Mail	ing Address (S	treet and Number or	Rural Route Numb	per, City or Town,	State, Zip Code)
			20a. Method of Disposition		20b. Place of Diso	3 46th S	of	ltimore,	Marylan	d 21224 City or Town, State
MBE	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F		oak Lawn	Cemete		/2005		ore, Maryland
DECEMBER	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens			22 Name and A	Address of Facility			
io a	Depa Depa Impo any ii		11)0.	· Caus	$\mathcal{Q}$		Ruck Funer Vise Ave.			
			23a. Part1 enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	e death. Do not en	nter the mode o	f dying, such as card	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a LUNG CANC	CER					Onset and Death
٦	/Medical Examiner		Tosuming in doubly	Due to (or as a co	onsequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. End of Julying Cause (Disease or injury	b. Due to (or as a c	onsequence of):					
2	cate be executed physician and sthe burial-transit	Examiner	that initiated events	с.						
\ A	Se execian a		resulting in death) Last	Due to (or as a co	onsequence of):					
687	physicate t	edicai		d						
		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date	e of delivery
Η	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		□Ectopic pregr □ Other (speci			Mor	nth Day Year
ERE	at the ded by the detached	Phy	9 Unknown		at societies is the		an anna in Bant I	220 Did	tobacco uso contr	ibute to the cause of death?
SCI	ires that signed b	by	Part II. Other significant conditions co	ntributing to death but s	or resulting in the	underlying caus	se given in Part i.			3 ☐ Probably 4 ☑Unknown
ROLD S	w require been sig	Completed				-		24a. Was		Vere autopsy findings available
HAROLD	The lav	ошо						auto perf	opsy pormed? d	rior to completion of cause of leath?
H.	vician: The	BeC	25. Was case referred to medical				26. Place of D	1 Tyes	- AX	(1165 2 NO
> *0	Physic This ce	To	1 165 21X 140	Hospital: 1   Inpatient			<del></del>	Home 5 ☐ Res	idence 6 🗖 Othe	or (Specify) HOSPICE
5	ding P	ion:	27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time (	of 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurre	ed
acioivi acioivi	Attending Physician: r death. sctor: Atter this certification, the funeral director, the funeral director director, the funeral director director, the funeral director director director, the funeral director dire	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, s					er or Rural Route Number,
Ë	al or A s after il Dire	Certi	4  Homicide determined	building, etc. (	Specify)	, , , , , ,		City or To	wn, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (		sician: To the best of n iner: On the basis of ex and manner stated	amination and/or i					
	To the within 2 To the complet	Me	29b. Signature and title of certifier				icense number		29d. Date signed	(Month, Day, Year)
			/1				43726		Dec.	15, 2005
	610		30. Name and address of person who c	ompleted cause of deat	th (Item 23a) (Type	, Print)				
1	Sta	ate.	DR. TARTO MAHMOO  31. Date filed (Month, Day Year)	32. Registrar's	ANEY VAL	LEY RD.	TIMONIU	M, MD 210	093	
	Registr		DEC 2 1 2	005	w St. A	TOO OF				

·85	47		1- For Amend Item 27 per ME, G850, 12721	artment of Health and Mo 705 dhb rtificate of Death	ental Hygie	ne .2005   127
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	3. Time of Death
	Physicia /Medic		James Edward Russell	Stokes	DECEMBER	<sup>□</sup> 1 <sup>1</sup> 8, 2 <sup>0</sup> 0 <sup>0</sup> 5 0605 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number) 8300 RACE TRACK ROAD	4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGES
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye Sept . 8 ,	9. Birthplace (State or Foreign Country) Virginia
	aryland •how	'n	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.  Md Princes Georges Bowie	ocation		10d. Inside City Limits 1 ☐ Yes 25No
	the M	Director	10e. Street and Number	10f, Zip Code	10g.	Citizen of What Country?
	3a or		8300 Race Track Road	20715		JSA
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F		14. Race - American Indian, Black, White, etc.
036	72 hours after death with the Maryland natural', or Items 23s or 28s-f ehow deat Exacilizat must be notified at	by	1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1 ☐ Yes 🏖 No Specify:		Specify: Black
Maryland 21215-0036	-	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g	b. Kind of Business/Industry
21	73	Соп	9th Hot	<del></del>		urel Race Track
/land	d be ental ked o	To Be	17. Father's Name (First, Middle, Last) Walter Douglas	18. Mother's Name Martha	Stokes	
	nd 2 ilith a 27 ls			ng Address (Street and Number or Rura) Third St.Blacks		
Baltimore,	0 0 == =		1 Description 3 Description State	osition (Name of matory or other place) Bapt.Ch.Cem.12/		c. Location - City or Town, State
<b>3altin</b>	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Licensee	2. Name and Address of Facility  • E • Hawkes Funer		
_	40 E € a		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	04 East Stree	t Black	stone, Va. 23824
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ned bywar with (	1	Interval Between
	/Medical Examiner		Due to (or as a consequence of):	, ,		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
8760,	te be executed ysicien and e buriai-transit	icai Exa	resulting in death) Last Due to (or as a consequence of):			
9	g physias the		o			
Box .	Physician: The law requires that the death certificate be executed tribic certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	uires that t signed by Id be detac	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
of Vital Records,	The law require sete hes been signage 2 should b	Completed			24a. Was an autopsy performed	
tal	iclan: Th certificete rector, pag	0	25. Was case referred to medical	26. Place of Death	Check only one	No 1 Yes 2 No
Ξ	nysick nis cer I direct	To B	examiner? 1   Yes 2   No Hospital: 1 □ Inpatient 2 □ ER/Outpatie			e 6 MOther (Specify)SCENE
	g fe		27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury (Month, Day Year)		8d. Describe how	injury occurred
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	TAY	8f. Location (Street City or Town, S	at and Number of Rural Route Number, State) \$300 Porce The Cleft
۵	ital or irs aft ral Di		shed row BL		Bo	sic, May land
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea  2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the caus id at the time, date	e(s) and manner ás stated. and place, and due to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Dey, Year)
,	2		I herde M. Kind was	OCME	DEC	CEMBER 19, 2005
	1		30. Name and address of person who completed ca e death (Item 23a) (Type  THEODORE MICHAEL  111	, Print) PENN STREET, <u>BA</u> LTIM	ORE. MARY	YLAND. 21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	•	THAIL.	
	Registi	ar	DEC 2 1 2005 Read & Sand	<i>P</i>		

Physici	an	Decedent's Name (I	First, Middle, L		HANI	101	77			2	Date of D Month	Day	Year	3. Timelof Dia
/Medic	cal	4a. Facility Name (If no	ot institution, a			TUL			Location of	of Death	11	2-92 4c. Co	2004 ounty of Dea	
Examir	ier			orial Hosp				umber					legany	
uneral		5. Social Security Num	nber 6.	Sex 7. 1 □ M 2 □ F	Age (In yrs. la			r 1 Year	If Under Hours		Date of B	irth	9. Bii C	rthplace (State or For ountry)
irector		218-52-28 Usual Residence of De		ILMM ZU C	57	Yrs.				S€	ept.18	3, 1948	M	7
Mo H			0b. County		10c. City,	Town or Lo	cation							10d. Inside City Lin
a-f oh lifted	ctor	WV	Hampsi	nire	Gre	enspr	ing				_			1 □ Yes 2 🗶
or 28	Dire	10e. Street and Number						p Code				10g. Citize	n of What C	ountry?
trem 21 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director	HC-86 Box	21	12. Was Decede	ent Ever in 11 S	12		26 <b>7</b> 22		gin? (Speci	fu Vac or N	USA	Bace - Am	erican Indian,
ritem	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li></ul>	2 Married	Armed Force	s?	-		_		gin? (Speci n, Puerto Ri	can, etc.)	1	Black, Whi	ite, etc.
Pal', o	þ	3 Widowed 4	4.5	If Yes, Give Year or Date			1 🗌 Yes	2 <b>X</b> No	Specify:			S	pecify: Wh	nite
'natu	Completed		5. Decedent's only highest g	Education grade com <i>pleted)</i>		16a. Dece (Give	dent's Usi	ual Occupa ork done d	ation during mos	t of working	,	16b. Kind	of Business	s/Industry
than he Me	du	Elementary/Second	lary (0-12)	College (1-4d	or 5+)							House	ina Tr	dustry
other.	Be Co	17. Father's Name (Fit	rst, Middle, La	st)			OHSU	ructi		er's Name (	First, Middle	e, Maiden St	-	Mustry
s marked o umatic eve	To B	Paul L.	Shanho!	ltz					Ali	ice E.	Lamb	ert		
ls ma		19a. Informant's Nam	e/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rural F	Route Numi	ber, City or T	own, State,	Zip Code)
m 27 her tr				oltz (wife		HC			1 Gre	eenspr		WV 26		r Town, State
or of			Cremation 3	☐Removal from Sta	re For	est G	matory or len	other plac	θ)	12-2-			•	
Importent: if he eny injury or of once.		4 □ Donation 5 21. Signature of Fune			1 1	Ce	mete:	ry and Addres	s of Facilit				nsprin	ng, W
eny ir			.0001	D.()	Jan )					Home		LLC WV 20	<b>5757</b>	
95 - F		23a. Part1. Enter the	disease, or co	emplications that cay	sed the death.	Do not en	ter the mo	de of dyin	g, such as	cardiac or r	respiratory	arrest,	3131	Approximate Interval Between
sician		tmmediate Cause (Fi		Utroni		RUC	TIVE	DUIL	MON	HAVE V	Dis	EASE		Onset and Deat
ledical		disease or condition resulting in death)	- 4	a	as a conseque					•/				O TO TOO
miner	_	Sequentially list cond	litions,	b										
ısıt	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or in)	ediate ving iurv	Due to (or	as a conseque	ence of):								
al-trar	xan	that initiated events resulting in death) Las		c Due to (or	as a conseque	ence of):								
physician and the burial-transit	icai E			d										
as the	ledi													
igned by the attending pl be detached for use as t	Physician/Med	23b. Was decedent p in the past 12 m		23c. If yes, outcome 1 ☐ Live birth	me of pregnan		]Ectopic ₁	pregnancy				23	d. Date of de	elivery Day Year
the at	/sici	1 Yes 2 1		4□ Pregnan 9□ Unknow	t at time of dea n	ath 5[	Other (s	pecify)					WOTH	Day
ed by detac	Ph	Part II. Other significa	ant conditions	s contributing to deat	h but not resul	ting in the u	inderlying	cause give	en in Part I		23e. Did	tobacco use	contribute t	to the cause of death
sign ld be	d by										1	Yes 2	No 3 □ P	Probably 4 Unkn
s peen s	Completed										24a. Wa		24b. Were a	autopsy findings avail
te has	E O										auto peri	opsy ormed? 2X No	prior to death? 1 \( \text{Ye}	
rtifica ctor, p	BeC	25. Was case referred	d to medical						26. Place	of Death (				
his ce Idirec	To	examiner?	0	Hospital:		R/Outpatie			4 🗀 140	rsing Home	5 ☐ Res	sidence 6	Other (Spe	ecify)
After t unera	ion:	27. Manner of Death Natural	5 Pending	28a. Date of I (Month,	Injury Day Year)	28b. Time o Injury	of M	28c. Injury Work			d. Describe	how injury o	occurred	
tor: /	Certification:	2 Accident 3 Suicide	investigat	be 300 Blace of	Injury - At hon	ne farm st			Yes 2 🗌	28	f. Location	(Street and I	Number or F	Rural Route Number,
d in b	erti	4  Homicide	determine		, etc. (Specify)	, , , , , , , ,		,,				own, State)		
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.		29a. Certifier	Certifying	Physicien: To the be	est of my know	rledge, deat	h occurre	d at the tin	ne, date ar	nd place, an	d due to the	e cause(s) ar	nd manner a	is stated.
he Fu	edical	one)		eminer: On the basi and manner		on and/or in	ivestigatio	n, in my o	pinion, dea	ith occurred	at the time			
Tot	Σ	29b. Signature and tit	tle of certifier	A.C.	tospi to	Diet	) 2	9c. License	number	0				nth, Day, Year)
	1		^	- 1/ \	TOSAN TU	W (3)	1	1) 6	> 11	25		11- 3	>0 - d	D05
_		30. Name and addres	1720	0	4				- • • •					

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	_	1 - State Registrar	State of Ma	•		rtment of H				Reg. No.	005	41139
Physici	an	Decedent's Name (First, Middle, Last)							2. Date of De Month	Day	Yea	
/Media		Marc		Skotar	ski				12	19	200	
Examir	ier	4a. Facility Name (If not institution, give st				4b. City, Town, or				40.00	ounty of De	
		Union Memorial Ho  5. Social Security Number 6. Sex		(In yrs. last birti	hday)	Balti If Under 1 Year	If Under	_	8. Date of Bir	th	9.1	N/A Birthplace (State or Foreign
Funeral Director			M 2XIF 82		rs.	Months Days	Hours	Min	(Month, Da Jan. 16	v. Year)		aryland
within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28a-1 show the Macifical Examination must be notified at	Director	10a. State 10b. County  Maryland N/A		10c. City, Town	or Loc		Balt	imor	e City			10d. Inside City Limits 1 X Yes 2 ☐ No
iff th	Dire	10e. Street and Number				10f. Zip Code				10g. Citize		•
ath w		6735 O'Donnell St					2122					tates
172 hours after dea "naturel", or iteme	by Funeral	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 □ Yes 2 1 N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cubar ☐ Yes ※XXNo			ecity Yes or No Rican, etc.)		Black, W	<i>mer</i> ican Indian, Inite, etc. White
d within 72 hou piene. rthen "nature it e Medical E	Completed I	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give k	ent's Usual Occupa kind of work done d OO NOT use retired,	uring mos	t of worki	ing	16b. Kind		ss/Industry
with ene.	шс	Elementary/Secondary (0-12) 8 Years	College (1-4or 5-		act	ory Line	Work	er		r	ever	Brothers, Co:
filed Hygid Sther		17. Father's Name (First, Middle, Last)							(First, Middle			
ed at b	To Be	John Maciolek  19a. Informant's Name/Relationship (Typ	a Print)	19h	Mailine	g Address (Street a			Giarko	er City or T	own State	e. Zin Code)
alth ar 27 is r trau		Mrs. Patricia Boi		er) 6	735	O'Donne		reet	Balt	imore,	Mar	yland 21224
Pages 1 ar		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemeter	y, crem	sition (Name of natcry or other place			2/23/2			or Town, State alk, Marylan
permit. Pages Department of Important: If I any njury or once.		21. Signatur Funeral Service License	Reed	2	22. D	Name and Addres Ouda-Ruck 922 Wise	s of Facili Fune	eral	Home o:	f Dund	lalk, and	Inc. 21222
Physician /Medical		23a. Part 1. Enter the disease, or complice shock, or head tailure. List only one immediate Cause (Final disease or condition resulting in death)	Coro	A		The mode of dying  The Disector Market				rrest,		Approximate Interval Between Onset and Death
Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and real director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of	of):	ndio Mu	,000	thy				Jeyrs
the death certifical / the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				230	d. Date of Month	delivery Day Year
quires that the dean signed by the a	b	Part II. Other significant conditions conf	ributing to death bu	ut not resulting in	the un	nderlying cause give	en in Part	1.	1	obacco use Yes 2 🛣		e to the cause of death?  Probably 4 Unknown
iysician: The law requir is certificate has been si director, page 2 should	Completed								24a. Was auto perfo 1 Yes		24b. Were prior death	autopsy findings available to completion of cause of 1? Yes 2 No
ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?						e of Death	(Check only	one)		
ing Physi After this c uneral dire	lon: To	1 ☐ Yes 2 ☐ No  27. Manner of D ath 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		tpatient Time of njury	28c. Injury Work	4 🗆 N		me 5 Resi 28d. Describe			Specify)
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, fa	rm, stre				28f. Location ( City or To		Vumber or	r Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	cal	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin one)		examination and								
To the I	Medi	29b. Signature and title of certifier				29c. License	nu <i>m</i> ber			29d. Date :	signed (M	onth, Day, Year)
⊢ s ⊢ ŏ	1	I MEN ME	)			AT 24	789ª	16		17	119/0	<u></u>
0	1	30. Name and address of person who con	mpleted cause of de			Print)		L.1	MD		• • • •	
St	ate trar	31. Date filed (Month, Day, Year)	32. Rigistra	ar's Signature	M	books	20/1	1	<u> </u>			

Dawn Siford O5-08584 crn

1 - For State Registrar

Plea

ise Type or Print in Black						
State of Maryland / D	epartment of Health and	Mental Hygie	ene ()	05	4	40
	Certificate of Death	Reg	J. No.			
e, Last)		2. Date of Death		V	3. Time	of Death
Michele	Siford	December	19,	2005	4:03	P
	45 Ob Ton of Davids 4 Davids		4. 0.			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physicia /Medic		Dawn Michele	Siford December 19, 2005 4:03 P M
Examin			4b. City, Town, or Location of Death 4c. County of Death
		Johns Hopkins Bayview Medical Center	Baltimore N/A  If Under 1 Year   If Under 24 Hrs.   8, Date of Birth   9, Birtholage (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 2/8-92-6884 1 M 2 TF 44 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Days Hours Min. October 16, 1961 9. Birthplace (State or Foreign Country) Mary Land
		Usual Residence of Decedent	
arylan show		10a. State 10b. County 10c. City, Town or Local National Property of the County 10c. City, Town or Local National Nation	ation 10d. Inside City Limits 1 ☐ Yes 2 🛣 No
he Me	ecto	MD Baltimore Dundalk  10e. Street and Number	
a or 2		8227 Peach Orchard Road	10f. Zip Code 10g. Citizen of What Country?  21222 USA
ne 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Specify Yes or No-
or ite		1 Never Married 2 Married 1 ☐ Yes 2 M No	Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 No Specify:  Specify:
ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	White
in 72	oiete	(Specify only highest grade completed) (Give k	ent's Usual Occupation included of Business/Industry included one during most of working ONOT use retired)
d with giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 years Houset	wife Own Home
al Hygin of the vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
ould to	Ţ	James Van Tassel	Patricia Stamboni
12 sh h and 7 is m traum			n Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Peach Orchard Road, Dundalk, Md. 21222
Heali Heali tem 2		20a Method of Disposition 20b. Place of Disposi	ition (Name of Date 20c. Location - City or Town, State
Pages ent of nt: If li	١,	1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other traumatic event, the Madical Exameter must be collified at once.	Ì		Name and Address of Facility Onnelly Funeral Home Of Dundalk, P.A.
88 5 8	Đ	Connectes 7	110 Sollers Point Road, Dundalk, MD. 21222
		23a. Pan1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	war Disease
Examiner		Due to (or as a consequence of):	
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
ecutec ind transi	Examine	Cause (Disease or injury that initiated events c.	
be exe		Due to (or as a consequence of):	
ficate physis the	edic	d	
death certificate be executed e attending physicien and of for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ E	Ectopic pregnancy 23d. Date of delivery
D 0 D	sicia		Other (specify) Month Day Year
that the sed by detach	Phys	Part IL Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
uires signe	ompleted by	Orshetes rellitus; Asthma	1 Yes 2 No 3 Probably 4 Unknown
s beer s shou	olete	Medel Abuse	24a. Was an 24b. Were autopsy findings available
The la	mo		autopsy prior to completion of cause of death?    Drys 2 □ No   Drys 2 □ No
cian: ertifice ictor, j	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
Phyeic this ca	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	
ding I h. After funer	tion	27. Manner of Death    Natural 5	28c. Injury at 28d. Describe how injury occurred Work?  M 1   Yes 2   No
Atten r deat ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree	et, factory, office 28f. Location (Street and Number or Rural Route Number,
tal or rs afte el Dir	Certification:	4 Homicide Soldminos building, etc. (Specify)	City or Town, State)
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funerel Director: After this certificete hes been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check only one)  One)  Certifying Physicien: To the best of my knowledge, death of the control of examination and/or investment of examination and/or investment of examination and manner stated.	occurred at the time, date and place, and due to the cause(s) and manner as stated. sstigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To th within To th compl	Me	29b. Signature and title of gertifier	29c. License number 29d. Date signed (Month, Day, Year)
,		( torneau)	O.C.M.E. December 20, 2005
JN C		30. Name and address of person who completed cause of death (Item 23a) (Type, P	•
<i>J</i> Sta	to.	31 Date filed (Month Day Year) 32 Registras's Signature	enn Street, Baltimore, Maryland 21201
Registr		DEC 2 1 2005 \ Heresan St.	from the same of t
MU 17 Dev 1/0	204	P	7

				100 1	State of Ma						Mental H		Legible.		
		•	1 - For Stata Registrar		State of Ma	ilylall	•		of De		vieritai ri	Rag. No	UUJ.	4   4	
	Physicia	e :	Decedent's Name (First, Midd	lle, Last)	C L	,					2. Date of D			3. Time of De	
7	Physicia /Medic		Albert	<u>C</u>	Ste	110		45 O.5. T	·		Decemb	ser 1	7 200 County of De	5 00	Ам
7	Examin	er	4a. Facility Name (If not institution  Johns Hopkin			edica	1 Center	46. City, 1	Bala	ation of Death		40	. County of De	atn	
	Funeral	, je	5. Social Security Number	6. Sex		e (In yrs.	last birthday)	If Under 1		Inder 24 Hrs.	8. Date of B	irth ay, Year)	9. Bi	irthplace (State or F Country)	-oreign
煮	Director		217–24–9456 Usual Residence of Decedent	1,0,1	M 2UF		75 Yrs.				January			ylánd	
	yland now		10a. State 10b. Count	,		10c. Cit	y, Town or Loc	ation						10d. Inside City	Limits
	e Mar	ctor	MD.	N/A		Ba	ltimore	9						1 XYes 2	No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Marcical Examinational be nutitied at	Funeral Director	10e. Street and Number 1708 Dundalk A	venue	Apt A4			10f. Zip (	Code 1224				tizen of What C ISA	Country?	
	ms 23	era	11. Marital Status		2. Was Decedent 8		S. 13. V			nic Origin? (S	pecify Yes or No Rican, etc.)		14. Race - Am		
9	or ite	/ Fur	1 Never Married 2 Ma	1	Armed Forces?  TY□Yes 2□N  If Yes, Give	10		Yes, speci	_	exican, Puerl <i>ecity:</i>	o Hican, etc.)	1	Black, Wh	ite, etc. Vhite	
Maryland 21215-0036	hours tural',	ed by	3X Widowed 4 □ Divorce		Year or Dates:		1		Occupation			16b K	and of Busines		
7	in 72	piet	(Specify only high Elementary/Secondary (0-12)	est grade	completed) College (1-4or 5	4)	(Give )	kind of work	done during retired)	g most of wor	king	100.1		amoustry	
2	filed will Hygiene other the	Completed	12 years		00110g0 (1 401 0		Traffi	ic Tec				_	timore	City	
and	ntal H ed oth	Be	17. Father's Name (First, Middle Albert C. Ste								ne (First, Middl C. Jas		Sumame)		
	should ind Men ind Men ind marke	T <sub>0</sub>	19a. Informant's Name/Relation		e, Print)		19b. Mailin	g Address			ral Route Num		or Town, State,	Zip Code)	
	and 2 Balth a n 27 is		Debra L. Willi	ams	Daughte					reet,	Baltimo	re,	Md. 212	224	
Baltimore,	permit. Pages 1 a Department of Hes Important: if Item any Injury or othe onca.		20a. Method of Disposition  1 XBurial 2 Cremation	3 []Re	moval from State		lace of Dispos	atory or oth	e of her place)	Dece			ocation - City o		
Ħ H	permit. Pages Depentment of I Important: If Its any Injury or o		4 ☐ Donation 5 ☐ Other (	Specify)		HO	ly Rede		Address of		2005	Bal	timore,	MD.	
Ba	Dep.		La thrus		. (m	nel	ly Co	nnell	y Fun	eral H	ome Of Road,	Dund	alk,P.A	21222	
	<del></del>		23a. Part1. Enter the disease, shock, or heart failure. Vi	or complic	ations that caused cause on each lin	the deat	h. Po not ente	or the mode	of dying, su	ch as cardiad	or respiratory	arrest,	ara, mr.	Approximate Interval Betwe	
в	Physician		Immediate Cause (Final disease or condition	a	Sepsi									Onset and Dea	ath
	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):	1		1	7.6			4.6	
		er	Sequentially list conditions, if any, leading to immediate	b.	Due to (or as	a conseq	uence of):	STOLA	t oto	iph I	hureu	7		uays	
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> c.											
760,	te be executed ysicien and e burial-transit		resulting in death) Last		Due to (or as	a conseq	uence of):								
687	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	edicai		d.				-							
Box (	n certifi anding use a	J/M	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outcome			Ectopic pre					23d. Date of d	elivery	
Э.	s death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Pregnant at			Other (spe					Month	Day Yea	ar
P.O.	hat the	Phy	9 ☐ Unknown  Part II. Other significant condi	tions cont	nbuting to death b	ut not res	ulting in the ur	nderlying ca	use given in	Part I.	23e. Did	tobacco	use contribute	to the cause of dea	ıth?
ds,	The law requires that the death certifica ete hes been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	metastatic	- (2)				oron		atten	/ 10	Yes 2	Хі́№ з□н	Probably 4 🗆 Unk	known
000	aw rec is bee 2 shou	piete	disease hype	vter	sion, d	iabi	etes,	chro	nic	1	24a. Wa	s an	24b. Were a	autopsy findings ava	ailable
ž	The I ete he page	EoC	Kidney dise	use							per 1 ☐ Yes	formed?	death?	~	30 01
Vita	Attending Physician: r death. sctor: After this certification the funeral director.	Be	25. Was case referred to medic examiner?	100	ospital:				Other		ath (Check only				
o	Phys	. To	1 Yes 2 No 27. Magner of Death		28a. Date of Inju	ry	ER/Outpatien 28b. Time of		Bc. Injury at	☐ Nursing H	lome 5 ☐ Re: 28d. Describe			ecify)	
ion	ath. r: Afte	ation	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Month, Da)	y Year)	Injury	м	Work? 1 ☐ Yes	2 🗆 No					
Division of Vital Records,	or Atta fler de lirecto n by th	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	not be mined	28e. Place of Inju- building, etc			et, factory,	office			(Street a.		Rural Route Numbe	or,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		292 Certifier X Certify	ing Etyesi	clan- To the best	of yew lone	rwladae death	occurred a	stite time d	eta and place	and due to th	e causals	and manner :	as stated	
	n 24 h	Medical			er: On the basis of and manner sta	examina									
	To the To the Con plat	2	29b. Signature and title of certif	ier	1, 0/2	1	24 0		License nur		275	~	ite signed (Moi		~
~		-	Pan. Noll	Jeg	un fle	MIY	220\ (T	2 : 13					ALLERY 1	7,2000	
4	5		20. Name and address of person 4940 Easter.	a A	Ve Bal-	AMO	11 238) (Type,	D 210	224	1401	LYEY	101	Veat	man N	IN
**	Sta		31. Date filed (Month, Day, Yea	r)	32 Registra	ar's Signa	Acces do	sale!	1		1 1		1		
V.	Regist	rar	ner. 2	7 200	J Line Course	with whi	J's all the same	the sufficient.							

			For State Registrar	State of M	aryland /	Departm <i>Certific</i>			Mental Hy	/giene	05	41142
	Physici /Medic		1. Decedent's Name (First, Middle, Nell'iE			uchik			2. Date of De Month	ber 17,	2005	3. Time of Death
1 to	Examin	er	9011110	yview Medic	ial Cont	er	Balt	Location of De	)		ty of Death	
	Funeral Director		5. Social Security Number 215–28–9472  Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last t	Yrs. Mont	nder 1 Year ths Days	Hours M	n. (Month, Di	<sup>rth</sup> a <i>y, Year)</i> er 23 <b>,</b> 193	9. Birthp Coun 1 Mars	lace (State or Foreign try) rland
	Maryland f ehow	ъ	10a. State 10b. County MD Baltin	moro		wn or Location					1	0d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-	Director	10e. Street and Number	WI6	D		. Zip Code			10g. Citizen of	What Cour	itry?
	23a o		6927 Eastbrook	Avenue			21224			USA		
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Iteme 23a or 28a-f ehow event. If a Medical Examinar must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' ed 1 Yes 2 1 If Yes, Give Year or Dates:	?		ecedent of His specify Cubar s 20 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	o- 14. Ra Bi	ice - Americ ack, White, ify: Whi	etc.
21215-0036	in 72 hou n"natura ledical E	Completed	15. Decedent' (Specify only highest	grade completed)	16	(Give kind or		luring most of v	vorking	16b. Kind of		
212	d within giene. or than "	Juno:	10 years	College (1-4or	5+)	Housew				Own	Home_	
	d be filed vintal Hygie	Be	17. Father's Name (First, Middle, L	-					lame (First, Middle	e, Maiden Suma	ime)	
Maryland	should nd Mer marke	٢	John H. Baier J.  19a. Informant's Name/Relationsh		15	9b. Mailing Add	ress (Street a		White Rural Route Numb	per, City or Town	n, State, Zip	Code)
	and 2 salth ar alth ar 27 le		Eve Reph	daughte	- 1	_			, Baltim			
Baltimore,	ges 1 and 2 should it of Health and Men If Item 27 le marke or other traumatic		20a. Method of Disposition  M☐ Burial 2 ☐ Cremation	3 □Removal from State	cemet	of Disposition tery, crematory	or other place		ember	20c. Location		
Ē	it. Pa rtmen rtant: njury		4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L		Oak L	awn Ce			,2005	Baltim		۵D.
Ba	Depa Impo any i		Christians (	(ann	eller	7110	elly F Solle	uneral rs Poir	HOme Of nt Road,	Dundalk Dundalk	,P.A.	21222
	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each  a	d the death. Do	f	mode of dying	11	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
3760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	с	RATIO a consequence a consequence		àn	Nosis				
P.O. Box 68	death certific e attending p ed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		of pregnancy 2 ∐ Fetal dea It time of death	= .	ic pregnancy r (specify)				ate of delive	ory Day Year
Ś	es be	þ	Part II. Other significant condition ESOD Vace a	rs contributing to death	but not resulting	in the underly	ng cause give	en in Part I.		tobacco use co		ne cause of death?
Record	The ete h page	Completed	Idiopathic	Throm	no chy	ropen	ia		24a. Was auto perf 1 🗆 Yes		. Were auto prior to col death?	psy findings available appletion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	AC.	eath Check only			
o	d is	7: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj	ury 28b	. Time of	28c. Injury Work	4   Nursing	Home 5 Res 28d. Describe	how injury occu		()
sion	Attending in death.  ector: After by the fune	atio	2 Accident 5 Pending investig	ation	ay rear)	Injury M		Yes 2 □ No				
Division of Vital	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ijury - At home, tc. (Specify)	farm, street, fa	ctory, office			(Street and Nun own, State)	nber or Rura	I Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying (Check only one) 1 Medical E	g Physician: To the bes Examiner: On the basis and manner s	of examination a	lge, death occu and/or investiga	rred at the timation, in my op	ne, date and pla pinion, death o	ace, and due to the courred at the time	cause(s) and r , date and place	nanner as si , and due to	ated. the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier	DO. A	20		29c. License		1	29d. Date sign	ed (Month,	Day, Year)
,			Meeling	Polo, I		A) (Turos Point)	RES-	000		Decem	be( )	8,2005
	Sta	10	30. Name and address of person \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	ENHOT	death (Item 23a	ACS BA	Trace	umeil	ICAL CO	SUTER	BA	70., md
187	Regist		nec 2	1 2005	2 10 1 1	5 Porce	Me 3					

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) Month MARGARET ALICE CONEY TRUNDA December 19, 2005 10:25 AM 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) 4c. County of Death MANOR CARE RUXTON Baltimore County Towson . Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1□M 2₩F Yrs May 25, 1913 Maryland 214-03-1304 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Baltimore County Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 118 E. Susquehana Avenue 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 NWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Clerk Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sadie Ozella Shaneybrook Carl Bernard Coney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Michael Seganish, Esq. (Guardian) 606 Baltimore Avenue, Towson, Maryland 21204 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Druid Ridge Cemetery 12/22/2005 Parkville, Maryland 21. Signature of Funeral Service iconsee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. PIGLICITI D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Pantl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a such as cardiac or respiratory arrest, Approximately a such as cardiac or respiratory arrest, CEREBROVASCULAR THROMBOSIS Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Due to (or as a consequence of): Due to (or as a consequence of)

**Physician** /Medical Examiner

physician and s the burial-transit

this certificate

or Attending Physicien:

efter death.

To the Hospital of within 24 hours e To the Funeral D

Director: /

Examiner

Physiclan/Medical

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Completed

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Certification:

Medical

State

Registrar

Department of Health.

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**Physician** 

/Medical

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

Saltimore, Maryland 21215-0020

7 is marked other than "netural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Did tobe	co use co	ntribute to the c	euse of death
1 🗆 Yes	2□ No	3 Probably	4 Unknow

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

Vas an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

2 XINO 1 TYes 2 No

28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. \

26. Place of Death (Check only one)

2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 4 Homicide

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 27. Manner of Death

1 Natural

29a Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifie

5 Pending investigation

29c. License number 29d. Date signed (*Month, Day,* 2)-0012849 12-19-05

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER Dr. TOWSON MD 21204 AH. GHILADI. 7600

31. Date filed (Month, Day, Year)

32. R'egistrar's Signature

Klein & frank

Box 68760. P.0. Division of Vital Records,

DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene  1 - State Registrer  Certificate of Death  Reg. No.											1 1 1 1	
U	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month , Day Year				
	nd 2 should be filed within 72 hours after death v lith and Mandal Hygiens a. Struckit, or frems 23a 27 lie markad other than "ratural", or frems 23a r traumatic event, the Madical Examinar austr	ai	Cynthia Teresa Teller December 19 300 1:40 MM  4a. Facility Name (If not institution, give street and number)  4b. City, Jawn, or Location of Peath  4c. County of Peath  Trank In Solvare Hospital Rose on Rose Rose Rose Rose Rose Rose Rose Rose									
**			5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1							ntry)		
_		ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland Baltimore 1 ☑Yes 2 □No									
		Director	10e. Street and Number		10f. Zip Code 21206				10g. Citizen of What Country?  U. S. A.			
21215-0036		Funeral	6505 Hilltop Ave  11. Marital Status  1 X Never Married  12. Was Decedent Armed Forces?  1 Yes 2 X N		Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,				r No- ) 14. Race - American Indian, Black, White, etc.			
		eted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi (Specify only highest grade)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					Specify: White 16b. Kind of Business/Industry		
12121		To Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Waitress  18. Mother's Name (First, Middle				Resteraunt			
Maryland					eller		Regin	a Kraus				
			19a. Informant's Name/Relationship (T Teresa J. Telle	c/ Sister	6505 H	Address (Street and	enue E	altimore	,Mary	land 2	1206	
Baltimore,	to to		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Ob. Place of Disposicemetery, cremata Sayview Cr	ttory or other place)	12/2			more,	own, State Maryland	
Balti	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licens	armello	22. 60	Name and Address	of Facility Mai	rzullo F Baltimo	unera re,Ma	1 Chap	el,P.A.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Approximate Interval Between Onset and Death Onset an									
			resulting in death)  Due to (or as a consequence of):  HOD CALLER C									
,8760,		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Ue to (y as a co s uen of):  C. Due to (or as a consequence of):									
9		/Medical	IF FEMALE:	d	agnancy					Barra of dall		
.O. Box		Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  1  Pregnant at time of death 5 Other (specify)						236.	23d. Date of delivery Month Day Year		
rds, P		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown				
of Vital Record		Completed						24a. Was a autops perfor	sy	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No	
Vita		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Hospital: All Placetiest 20 500 Other: 40 Nursing Home 50 Peridence 50 Other (Secret)								
		tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	y 28b. Time of 28c. Injury at 28d. Describe				o how injury occurred			
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (									stated. to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of certifier  29c. License number						29d. Date signed (Month, Day, Year)			
	2	30. Name and address of person which completed cause of death (Item 23a) (Type, Print)									21733	
	Sta Begist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar 2 1 2005	Signature	Loude	onve	DOJ. +(//	10th	110	21-57	

			riease i			anariment of L			_	•
		4	For State	State of Ma	•	epartment of H De <i>rtificate of</i>			2005	41145
			Registrar  1. Decedent's Name (First, Middle, Last)			ortinoate or	Doutin	2. Date of Dea	eg. No.	3. Time of Death
	Physicia		Lillian Gladys T					Month	r 13, 200	r
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. County of De	
1	Examin	21	11812 Greenleaf A			Potomac			Montgon	nery
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	0.6	irthplace (State or Foreign Country)
	Director		578 <b>-</b> 09 <b>-</b> 1399	M 201F	93 <sup>Y</sup>	rs. Mortins Days	Tiodis Will.	Nov. 7,	1912 Wa	shington, DC
	р ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d, Inside City Limits
	show	5								1 ☐ Yes 2 ☑ No
	ith the Ma or 28a-f	ect	Maryland Montgome  10e. Street and Number	ry	Potomac	10f. Zip Code			0g. Citizen of What	Country?
	with	2	11812 Greenleaf Av	07110		20854		1	Jnited Sta	
	ns 23	Funeral Director		12. Was Decedent	Ever in U.S.	13. Was Decedent of H				nerican Indian,
(0	or Iter	필	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉	lo l			o Rican, etc.)		nite, etc.
93	72 hours alter death with the Maryland natural', or Items 23a or 28a-f show Iteal Examenat must be inclifted at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	Vhite
5-0	72 hours after death w "natural", or Items 23a edical Examinational	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. [	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of wor	rking	16b. Kind of Busines	ss/Industry
21	within ene. than *	ig I	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use retire Homemaker	d)		Own Home	
2	lled Tygi nt.	ပ္ပ	12 17. Father's Name (First, Middle, Last)			Homemaker	18. Mother's Nar	ne (First, Middle,		
and	ted o	o Be	John E. Kramer				Luli	Holtzcla	aw.	
Maryland 21215-0036	2 should be f and her tal b Is marked of aumatic eve	P .	19a. Informant's Name/Relationship (Ty	pe, Print)	19b.	Mailing Address (Street				, Zip Code)
	s 1 and 2 should 1 Health and Mentitem 27 is marks other traumatic		Stuart O. Thompso	n/Husband	1 11	1812 Green1	eaf Aven	ue, Potor	mac, Maryl	and 20854
Baltimore,	ss 1 and 2 of Health item 27 l		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other pla		Date	20c. Location - City	
Ë	0 0		1 ☐ Burial 2 XCremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Montgo	mery orium. Inc.	16.	2005	Bethesda,	Maryland
alti	permit, Pa Departmen Important: any Injury once.	1	21. Signature of Funeral Service License	90	or oma o	22. Name and Addre	ss of Facility Rol	bert A. I	Pumphrey I	uneral Home/ Avenue
Ω	Depi Imp		في المالي المالي	· pur	M00803	Rockville.	Maryland	d 20850-	-2805	Avenue
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause in each lin	the death. Do no	ot enter the mode of dyi	ng, such as cardiad	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Atheros	sclerat	ic card	iovascu	lar dis	sease	years
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o					
	«	_	Sequentially list conditions,	)	a consequence o	N.				
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dag to (or as	a consequence o	<i>I</i> -				
	be executed sician and buriat-transit	xar	that initiated events resulting in death) Last	Due to (or as	a consequence o	i):				
760,		cai		1 -						
68	certiticat nding phy ise as the	edic								1
Вох	leath certiticate attending phy I for use as the	an/N	23b. was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Petal death	3 ☐Ectopic pregnanc	v		23d. Date of d	,
	deat ed for	by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 👿 No	4☐Pregnant at		5 Other (specify)			Month	Day Year
P.0	that the de ed by the a detached	Phy	9 Unknown				in Doubl	220 Did to	hanna ugo gentributo	to the cause of death?
ŝ	Se uga		Part II. Other significant conditions con	imputing to death b	at not respiting in	ine underlying cause gr	venin ranti.	1 □ Y	1 /	Probably 4 Unknown
Records,	w require been si should I	Completed								
3ec	e law has t	mpi						24a. Was a autop: perfor	sy prior t	autopsy findings available o completion of cause of ?
alF								1 Tes	2(XNo 1 □ Y	
Vital		o Be	25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No	lospital:	ent 2 ER/Out	patient 3 DOA		ath (Check only or	ence 6 $\square$ Other ( $S_i$	agaiful
of	g Physical this neral di	H- 1	27. Manner of Death	28a. Date of Inju	ry 28b. Ti	me of 28c. Inju	ry at		ow injury occurred	Jecny)
lon	f A j	tiol	1 Natural 5 Pending investigation	(Month, Da	y rear) in	jury Wo M   1⊡	rk? ]Yes 2 □No			
Division	Attendi er death. ector: A by the fu	Illica	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, far c. (Specify)	m, street, factory, office		28f. Location (S City or Tow	treet and Number or n. State)	Rural Route Number,
D	s afte	Certification;		Dundang, or	o. (opco.ry)					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	cai	(Check only 2 Medical Exami	ner: On the basis o	f examination and	death occurred at the to				
	To the P within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner sta	ated.	29c. Licen	eo numbor		29d. Date signed (Mo	onth Day Year)
	To Too		29b. Signature and title of certifier	on the	Man	mx D	51916	-		
,		7	Javiera 1	mojer	leath (lt == 22=)	Type Print	51110		pec, 1,	1, 2005 le. MD 20851
1			30. Name and address of person who co	Displeted cause of c	(190 23a) (	Pockville	Pike, 6	3-100.	Rockuil	le MD 20851
	Sta	te	31. Date filed (Month, Day, Year)	32. Pygistr	ar's Signature	Searl 1		100/1	V// V 1//	-1
	Regist		DEC 2 1 2	UUD J	was D.	MEN STATE OF THE S				

				Pleas			in Black Ir			•		•	
			For State Registrar		State	OI War	yland / Dep <i>Ce</i>	rtificate of		ivientai ny	/giene Reg. Na	200	41146
	· ·		Decedent's Nam	e (First, Middle	, Last)					2. Date of D Month			3. Time of Death
	Physici /Medic		JOSEPH		WALDYCH					DECEME	BER 1	8, 2005	9:30p <sup>M</sup>
	Examin	er		MARIS	HOSPICE		t t t t t t t-		or Location of De- TIMONIUM r If Under 24 Hi	1			TIMORE
	Funeral Director		5. Social Security N 213-14- Usual Residence o	2558	6. Sex 1 Mg M 2 □ F	7. Age (/	n yrs. last birthday 85 Yrs.	Months Days			пп ay, Year, -192(	) 9. Birth Cou	place (State or Foreign ntry) RYLAND
	yland		10a. State	10b. County		10	Oc. City, Town or L	ocation					10d. Inside City Limits
	the Marylar 28m-f ehow octified at	ctor	MD	BA	LTIMORE			I	ROSEDALE				1 ☐ Yes 2 No
	th with the 23a or 2	al Dire	10e. Street and Nu 9527 SH		COURT			10f. Zip Code 2	1237		10g. Ci	tizen of What Cou	
5-0036	s 1 and 2 should be fitted within 72 hours after death with the Maryland f Health and Mental Hygiane. Item 27 Ie marked other then "neturel", or Items 23s or 28s-f ehow other traumatic event, Its Mudical Exaction from be neithed at	by Funeral Director	11. Marital Status 1 □ Never Marr 3 □ Widowed			2 No	ĺ	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No	Hispanic Origin? ban, Mexican, Pue o Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
5-0	neture!,	eted	(Spec	15. Decedent	's Education t grade completed	1)	(Giv	edent's Usual Occi	e durina most of w	rorking	16b. K	(ind of Business/I	ndustry
121	within ane.	Completed	Elementary/Seco	ondary (0-12)	T	(1-4or 5+)	life.	SUPERV			WE	ESTERN EI	ECTRIC
d 21	should be fited within and Mental Hygiane. marked other then matic event, I'm Ma	Be Co	17. Father's Name		Last)			SUPERV		ame (First, Middle	a, Maider	Sumame)	
ılan	should be find Mental he marked of	To B	JOSEPH	WA	TDACH				ANN	JA (SZ	ZAJNE	ER)	
Maryland	2 sho and h le ma auma		19a. Informant's N	ame/Relations	nip (Type, Print)		19b. Mai	ing Address (Stree	et and Number or i	Rural Route Numi	oer, City	or Town, State, Zi	o Code)
	1 and dealth om 27 sher tr		CATHERI 20a. Method of Dis		YCH/ WIF		952 20b. Place of Disp	THE RESERVE OF THE PARTY OF THE	OOD COURT	ROSE	-		21237
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If item 27 It eny injury or other tra once.		1 <mark>√</mark> Burial 2	☐ Cremation	3 Removal from		cemetery, cri	matory or other pi	1			ocation - City or T ${f ALTIMOR}$	
altir	permit. P Depertme Importan eny injuri	1	21. Signature of Fi	5 □ Other (S <sub>i</sub> uneral Service I				NISLAUS ( 2. Name and Add		-22–2005	ъ.	ADITMON	E, MD
ä	Depermine on in in poor			2 Se	_( X	-							
Page 1	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	art failure. List (Final on	a. SEP:	SIS	e death. Do not en	iter the mode of dy	ring, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
760,	sath certificate be executed attending physician and for use as the burial-transit	sal Examiner	Sequentially list or if any, leading to it cause. Enter our Cause (Disease or that initiated event resulting in death)	S	с.	`	onsequence of):						
.O. Box 687	the de	Physician/Medica	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months? □ No	23c. If yes, o	birth 2 gnant at tim	Fetal death 3	⊒Ectopic pregnan ⊒ Other (specify)	су			23d. Date of deliv Month	ery Day Year
S, P	w requires that been signed b should be deta	þ	Part II. Other signi	ficant condition	ns contributing to	death but n	ot resulting in the	underlying cause g	iven in Part I.				he cause of death?
ord	requir	eted								. 10	Yes 2	UNo 3□Pro	bably 4 XUnknown
al Records,	The ate h page	Completed								24a. Was auto perf 1 Yes	opsy ormed?	prior to co death?	opsy findings available impletion of cause of
of Vital	Physician: r this certific ral director,	o Be	25. Was case reference examiner?  1  Yes 2		Hospital:	Inpatient	2 ER/Outpatie	nt 3 DOA		eath Check only		e ViOthos (Casa	b) HOSPICE
ion of	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	ation: To	27. Manner of Dea 1 XNatural 2 Accident	th 5 🗌 Pendin investig	28a. Dat (Mo	e of Injury onth, Day Y		of 28c. Inj		28d. Describe			W HUSPICE
Division	al or Atters after de	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could r determ	ned 286. Pla	ce of Injury Iding, etc. (	- At home, farm, s Specify)	reet, factory, office	)	28f. Location City or To		nd Number or Rur e)	al Route Number,
	To the Hospital within 24 hours and the Funeral completely filled	edical (	29a. Certifier (Check only one)	1 Certifyin 2 Medical	xaminar; On the	he best of n basis of ex anner stated	ny knowledge, dea amination and/or i d.	th occurred at the nvestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s , date an	) and manner as s d place, and due t	stated. o the cause(s)
	To the To the Comp	Σ	29b. Signature and	title of certifier					nse number			te signed (Month,	
•	11		,		/ /				13725		/	12/19/0	5
	Sta	3.5	DR. TA	RIQ MAI	MOOD 23	800 DU	LANEY VA	LLEY RD.	TIMONII	JM, MD 2	1093		
1	Registr	ar .		DEC 2	1 2005	RICH	Signature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month Dav Year Physician MILLIAMS AN SHERYL 0505 December 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner City DA If If Under 1 Year MORE If Under 24 Hrs. SOMNIS 40PKINS 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number **Funeral** Days Months Hours Min 1□M 2√F 41 Director 217-84-6149 10-9-64 Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or itams 23a or 28a-1 ehow amy njury or other traumatic event, in Medical Exercit at investigation once. 1 ☑ Yes 2 ☐ No Funeral Director Md. NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 259 S. Herring Court 21231 USA 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade NA Unemployed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Williams Schellie Louis Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 259 S. Herring Court , Baltimore, Md. 21231 Schellie Williams Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-27-05 Dundalk, Md. Mt. Carmel Cem. 22. Name and Address of Facility 21. Sibnatu e of Funeral Service License Baltimore, Md. 21202 1101 E. North Ave. March F.H. East Enter the disease, or complications that caused it, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. te Cause (Final or condition in death) Pheumoccoca **Physician** Hours /Medical Due to (or as a consequence of) Examiner Human Immunodeficiency Virus veurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physicien a s the burial-Box 68760, Physician/Medicai attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ₹Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date ol Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 THomicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO, PhD RES-000 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Or toad Kolb the Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287 31. Date liled (Month, Day, Year)
DEC 2 1 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	arylan	•			ealth a Death	and Me	ental Hy	gien Reg. N	211115	terminosaa	48
	Physica		Decedent's Name (First, Middle, Last     Donald		Vilan	đ					2. Date of De Month Decem	D	,		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City	Town, or	Location o	f Death			c. County of Dea		*
**			1929 Artillery I	Lane				Oder				1	Anne Arı	undel Co	
	Funeral Director		5. Social Security Number 6. Se 214–36–8256	7. Ag	e (In yrs. 66	Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bio (Month, Da March	y, Year		rthplace (State o ountry) 110	r Foreign
	put 🖈		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	tv Limits
	e Maryla Ba-1 eho	ctor		Arundel					Odent	on				1 🗆 Yes	
	with th	Dire	10e. Street and Number	no			10f. Z	p Code	21113	3			itizen of What C		
	e 23e	eral	1929 Artillery La	12. Was Decedent	Ever in II	S 12 1	Was Door	dont of Hi			ofy Ves or No		ited Sta		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23e or 28a-f ehow supprigning or other traumatic event. The Medical Evantian must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 24 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1X Yes 2 1  If Yes, Give Year or Dates:	No		If Yes, spi		n, Mexican	, Puerto F	ofy Yes or No Rican, etc.)	,	Black, Wh		
21215-0036	2 hou	ted	15. Decedent's Ed	ucation		16a, Decer	dent's Usi	al Occupa	ation			16b.	Kind of Busines	s/Industry	
215	hin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or !	5+)	(Give	kind of w DO NOT i	ork done d ise retired	during most DAud	itor	g			urities	
21	giene giene r the	E O		6 Years+		Certi	fied	Publ						Commiss	ion
Maryland	uld be filed flental Hygie rked other tic event.	To Be (	17. Father's Name (First, Middle, Last)  George W. Wilar	ıd							(First, Middle rguson	, Maide	n Sumame)		
Mary	1 and 2 should Health and Men tem 27 is marke		19a. Informant's Name/Relationship (T Mrs. Glenda Lee Wi		fe)				and Numbe y Lan		Route Numb denton	er, City Mâ	or Town, State, aryland	Zip Code) 21113	
nore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		C	lace of Disponentery, cremetery, cremetery, cremetery	matory or	other plac	e)   k Cem		ate /17/20		ocation - City o		
Baltimore,	permit. P Departme importan eny in[ur.		21. Signature of Funeral Service Licens		4	_   22 D	2. Name a	nd Addres	s of Facility Funer	y cal H		Du	ndalk,		
Ř,	·		23a. Part 1. Enfer the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused one cause on each li	d the death								yrana	Approximate Interval Bette Onset and I	ween
)	Physician /Medical Examiner		disease or condition resulting in death)	a. Pancr Due to (or as		Cance of):	er							Years	
18	uted 1 ansit	Examiner	Sequentially list conditions, a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consuq	uence of):									
8760,	cate be executed physician and the burial-transit	cal	resulting in death) Last	Due to (or as	a conseq	uence of):									
9	ng ph	Med	IF FEMALE:						1617-06						
.O. Box	he death certifica the attending ph thed for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	death 3	□Ectopic i □ Other (s	pecify)					23d. Date of de Month	•	/ear
s, P	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions co	ontributing to death b	out not res	ulting in the u	nderlying	cause givi	en in Part I.					to the cause of d	
Record	e - 6	Completed									24a. Was auto perfe	psy ormed?	prior to death?	autopsy findings completion of c	available ause of
a	ilcian: Th certificate rector, pag	e C	25. Was case referred to medical						GE Blace	of Dooth	1 Yes	2E N	o 1 🗆 Ye	s 2 No	
Vital		To B	examiner?	Hospital: 1 🗌 Inpatie	ent 2	ER/Outpatier	nt 3 🗆 D	OA Oth					6 □Other (Sp	ecity)	
10	g Phy er this eral c		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o		28c. Injun Worl			8d. Describe			ocity/	
0	Attending r death. ector: After by the fune	atlo	1 <sup>4</sup> Natural 5 ☐ Pending 2 ☐ Accident investigation	(1910)1111, 20	,y , o.u.,	angory	М		Yes 2 1	No					
Division of	al or Attend s after death i Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ury - At ho	ome, farm, str y)	reet, facto	ry, office		2	8f. Location ( City or To			Rural Route Num	ber,
	To the Hospital or Attending Physimiting 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical (		ysicien: To the best iner: On the basis of and manner st	f examina										)
	To the within 2 To the complet	M	29b. Signature and tyle of certifier	^			25	c. License	e number			29d. D	ate signed (Mor	nth, Day, Year)	
)	, (		1 4 4 Mus	MU				D-3	4868			DRC.	13,2005		
10	11/1		30. Name and address of person who of Steven Diener, I		death (Iten 55 Li	ttle P	Print) atux			Suit			ımbia, N		.4
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 2 1	32. Resisti	rar's Signa	iture	book	1							

CYNTHIA 05-08557 RKD D.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

WILLIAMS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 = For State Registrar	end item#2	ع,21	State c	i Mar	ryland		artment or artificate				1ental H	ygie Reg.	200	En	1, 1 1 1	0
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/Medical xaminer		e (If not institution	, give stre	eet and nu	mber)			4b. City, To	wn, or	Location	of Death			4c. County of	Death		
	7280 MC	NTGOMERY	ROA	D				ELKRI	DGE	C				HOWARD			
eral	5. Social Securi	ty Number	6. Sex	4 25xF	7. Age	(In yrs. las		If Under 1 ' Months E	Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Day, Ye	ar)	Coun		
or	577-96		1 🗆 🛚	1 20 <u>x</u> 1 r	40		Yrs.					Nov.	2,	1965 Wa	shi	ngton, I	OC_
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Be		Williams									y Da	,		<b>--</b>			
ြင		's Name/Relations		. Print)			19b. Maili	na Address (S	Street a				ber. Ci	ty or Town. Sta	ate. Zip	Code)	
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	20a. Method of		FIOCII	EI		20b. Plac	e of Dispo	sition (Name	of			Date		Location - Cit		wn, State	
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Ĺ	23a. Part En	ter the disease, or	complica	tions that	caused th	he death.	24100000			-			-	on, Do	200	Approximate	
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Completed												24a. Wa	opsy	OFIO	r to con	sy findings avai	lable e of
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<u>S</u>	27. Manner of I 1 ☐Natural	5 ☐ Pendin		End <sup>Mor</sup>	nth, Day	Year)	8b. Time c		Worl	k?	TAIL .		e now i	njury occurred			
icat	2 Accide	e 6 Could	not be	Dec.				Рм		Yes 2 💢	INO I	29f Location	(Stmo)	t and Number	as Pura	Pouto Number	
Certification:	4 🗆 Homic		ined	build	ling, etc.	(Specify)		reet, factory, o	опісе			City or T	own, S	tate 7280 I	Monte	Route Number.	xd
	29a. Certifier	1□ Certifyir	o Physic			Vehic		h occurred at	the tim	ne date a	nd place			e(s) and mann	or ac et	atod.	
Medical	(Check only	2X Medical	Examine	r: On the t	basis of e	xaminatio	n and/or in	vestigation, in	nny o	pinion, dea	ath occur	red at the tim	e, date	and place, and	due to	the cause(s)	
Me	29b. Signature	and title of certifie	r		. 51410	-		29c. L	_icense	e number			29d.	Date signed (A	Month, L	Day, Year)	
	1	net Ka	Alos.	/ n.A				0	.C.	M.E.			DEC	CEMBER	19.	2005	
	30. Name and	address of person	who com	pleted cau	se of dea	ath (Item 2	3a) (Type								<b>,</b>		
	Prime	ek E. Sa	tho. 1	/ ml		(	, () PO		ENN	V STR	EET :	BALTIM	ORE	MARYLA	ND 2	21201	
State	31 Date filed /	Month, Day, Year)	1. 2.1	32	Registrar	's Signatu	ro										

State Registrar

			1 - State Registrar	State of Mar	yland / [		artment of H		and M	, ,	iene		
	Physic		1. Decedent's Name (First, Middle, Las		WIL	41	AM5	<u></u>		2. Date of Deat  DECEMB	h	7 Les	3. Time of Death 6.5 8:20 A M
	/Medi Exami		4a. Facility Name (If not institution, give 2 Bristol Hill Ct.	street and number)	•		4b. City, Town, or			VL CLIID!	4c. Cc	ounty of De	eath
		20 1					Caton					altim	
10	Funeral Director		219-20-2203	M	In yrs. last bir	Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day, 09/23/]	934	9. B	Birthplace (State or Foreign Country) Aryland
	and and		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Tow	n or Lo	cation	_					10d. Inside City Limits
	Mary -1 sh	to	Maryland Baltimor	re	Cato	onst	ville						1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizer	n of What (	Country?
	th wit		2 Bristol Hill Ct	. Apt B-3			21228			111	nited	l Star	tes
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Orig	gin? (Spe		T		nerican Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-1 show he Medical Exartment that be notified at	by Fu	1 ☐ Never Married 2 【※ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give		1	☐ Yes 2☒No			, , , ,	Sp	pecify:	White
8	tural tural	ed b	15. Decedent's Ed	Year or Dates:	16a	Deced	ient's Usual Occupa	ation			16h Kind	of Busines	os/lodustri
15	n "ne	piet	(Specify only highest grad	de completed)		(Give )	kind of work done of NOT use retired,	during most	of working	9	100, Killu	OI DUSINGS	samuustiy
212	giene.	Completed	Clementary/Secondary (0-12)	College (1-4or 5+)	Po	olic	e Office	r			Law	Enfo	rcement
pu	be filed within 72 hatal Hygiene. d other than "netuevent, the Medical	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, A	Maiden Su	imame)	
yla		P	Wilbur J. William							M. Rich			
Maryland 21215-0036	12 sho h and 7 is m		19a. Informant's Name/Relationship (7)	**			g Address (Street a						
	s 1 and 2 should t Health and Mer Item 27 is marke other traumatic		Janice Williams,										MD 21228
Baltimore,	00		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval mont State			sition (Name of place of other place of the Cem.						, Maryland
華	그 돈 본 글 .		21. Signature Therry Serve Licens		Houdoi								
ñ	Depa Impo sny ir		Viffe	) MC	01290	16	Name and Address 30 Edmone	eral 1 dson 1	Home Ave.	Catons	nsvi ville	.IIe,	Inc. 21228
學			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	e death. Do n							,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mypco	21 de	al	In tal	retu	150				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence	of):	1						
	3	<u>.</u>	Sequentially list conditions,	b. Due to (or as a	pe	$\mathcal{J}V$	remi	01					
	uted n	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as ap	on <b>yo</b> quanca c	ון.							
Ć.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence	of):					-		
8760,	cate be executed bhysicien and the burial-transit	dicai		d									
89		Med	IF FEMALE:										
Вох	death certifi e ettending p ad for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1☐Live birth 2 ☐		3 🗆	Ectopic pregnancy				23d	i. Date of d	,
o.	the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□ Unknown	ne of death	5 🗆	Other (specify)			<del></del>		Month	Day Year
0.0	that the de ed by the detached	Ph	Part II. Other significant conditions co	ntributing to death but r	not resulting in	the un	deriving cause give	n in Part I.		23e. Did tob	acco use	contribute	to the cause of death?
Division of Vital Records,	The law requires that the side has been signed by those 2 should be detached.	d by		•	3		, <b>y y</b>			1 □ Ye			Probably 4 □Unknown
Ö	s been s shoult	Completed								24a. Was an	2	4b. Were	autopsy findings available
Re	The lav	E					-			autopsy	red?	prior to death?	completion of cause of
ita		BeC	25. Was case referred to medical				-	26. Place	of Death	1 ☐ Yes 2 Check only one	ØNo _	1 🗆 Ye	es 2 No
<u>~</u>	Physic this ce	2	examiner? 1 ☐ Yes 2 ☑ No	fospital: 1  Inpatient	2 ER/Out	patient	3□ DOA Othe	r: 4 🗆 Nur	sing Hom	e 5 Aesidei	nce 6	Other (Sp.	ecity)
Ē	Attending Physician: r death. ector: After this certification the funeral director.	 	27. Manner of Death 1 ■Natural 5 ■ Pending	28a. Date of Injury (Month, Day Ye	9a <i>r)</i> 28b. T	ime of	28c. Injury Work			d. Describe ho	w injury o	ccurred	
Sic	death. ctor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	On Discould	4.1			′es 2 □ N					
<u>≥</u>	i or Attendate after death Director:	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (\$	- At nome, far Specify)	m, stre	et, factory, office		28	City or Town,		umber or F	Rural Route Number,
	0 3 b E	edical C	29a. Certifier 1 Certifying Phy (Check only 2 ☐ Medical Exam)	sicien: To the best of m ner: On the basis of ex	ny knowledge,	death	occurred at the time	e, date and	place, ar	d due to the ca	use(s) and	d manner (	as stated.
	ਵੇ ਦੇ <b>ਰ</b>	Med	29b. Signature and title of certifier	and manner stated	1.								
	F. 3 L 8	_	200. Signature and the of certifier	2- 111			290. License	1211	4	1 29	U. Date si	gnea (Mor	10 7 CV
, [	1	-	30. Name and address of person who co	empleted square of death	h (Item 22=\ /	Turo C	sint)	- 10 Y	1	$\mathcal{J}$	econ	wes	17, 2003
1			SAMBAND AM BA  31. Date filed (Month, Day, Year)	8KLOW	3467	- W	ekens	Ave	6	ALTIME	RE,	MD	19 2005 21223
35	Stat Registra		DEC 2 1 2	1005 June	Signature /	A	and .						

			For State Registrar	State of M	laryland		rtmen <i>tificat</i>			d Mental Hy	ygiene Reg. No.	005	41152
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Gloria	Marie	W	illia	ıms		2. Date of D Month Decem b	Day	2005	3. Time of Death 13 42— PM
	Examin		4a. Facility Name (If not institution, give Union Memorial Ho	spital			Ва	altim				County of Deat	-
e de	Funeral Director		212 20 1123	7. A	ge (In yrs. ias 74	st birthday) Yrs.	Months	1 Year Days	Hours M	in. (Month, D	irth Pay, Year) 1–193	0	hplace (State or Foreign untry) Md
	show	2	Usual Residence of Decedent  10a. State 10b. County	/A		Town or Lo	cation						10d, Inside City Limits 17 Yes 2 □ No
	th the N or 28a-f	Director	Md N	, A	Да	110	10f. Zip				10g. Citiz	zen of What Co	untry?
	s 23a c	raiD	4512 Belvieu A		A Francis III C	10.1	N D		215	(Coord Vor as N		S A	don Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Ptyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumatic event, the Medical Experiment must be notified at anote.	by Funeral I	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 A If Yes, Give Year or Dates:	:? ] No	1	was Dece f Yes, spe I ☐ Yes	cify Cubai	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nierto Rican, etc.)		Black, White	e, etc.
Baltimore, Maryland 21215-0036	nin 72 ho n "naturi Medical J	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(54)	16a. Deced (Give life. L	ient's Usu kind of wo DO NOT u	rk done a	uring most of a	working		nd of Business/ ltimore	
121	led with lygiene her the		12th grade	College (1-4or	N/A	C1	erk		40 Mathada	Name (First, Middl	He	alth De	partment
lanc	uld be fi dental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last)  Charles T. Adams						Elinor		e, maiden .	Sumame	
Mary	12 sho h and h 7 is ma trauma		19a. Informant's Name/Relationship (Ty		_		-			Rural Route Num. Baltime	-		
re, l	of Healt item 2 rother	1	Phyllis Williams - 20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Na	ne of		Date		cation - City or	
tim E	t. Page nument c rtant: If njury or		14 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	_	e	ison	Fore	est \	et 12-	22-2005	Ow	ings Mi	.11s, Md
Bal	Department of the partment of		21. Si meture of Funeral Service Livens	- nee	2	22	. Name ar			arch F/H bash Ave		t Balto,	Md 21215
	Physician		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that cause ne cause on each aCarc	ed the death. line.	Do not ent	er the mod Hh mi	de of dying	g, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death H nows
	/Medical Examiner			Due to (or a	estive	ence of):" Head	rt 1	fai lu	Arres ue				10 years
	bed isst	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence of):							1
oʻ	cate be executed oblysician and the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):							
68760,	ficate be physical s the bu	edicai	•	d									
Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal c	death 3	]Ectopic p ] Other (s <sub>f</sub>				2	3d. Date of del Month	ivery Day Year
ds, P.O.	w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions co	ntributing to death	but not result	ting in the u	nderlying (	ause give	on in Part I.		1	se contribute to	the cause of death?
Division of Vital Records,	The law req te has beer age 2 shou	Completed					_			24a. Wa aut per 1 □ Yes	s an opsy formed? 2 <b>A</b> No	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	ician: Sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital: X.		- 00		Othe	vr.	Death Check only	one)		
on of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion; To	1 Yes 2 No '  27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		P/Outpatier 28b. Time of Injury		28c. Injury Work	4   Nursin	g Home 5 Res			cify)
Divisi	al or Atten s after dea il Director ad in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of li building,	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factor	y, office			(Street and own, State)		ıral Route Number,
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes ner: On the basis and manner	of examination	rledge, death on and/or in	occurred vestigation	at the tim	e, date and plainion, death o	ace, and due to the ccurred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	To ti Withi To ti	Σ	29b. Signature and title of certifier	ren,	DO			c. License	3894	+6		signed (Monti	7, 2005
1	21		30. Name and address of person who o	ompleted cause of	death (Item :	23a) (Type,	Print)			P	~ ~		.,
	Sta	to	Lopa Basu, D. o. 31. Date filed (Month, Day, Year) DEC 2 1 2005	. Union	Mem strar's Signatu	orial	Hos	spit	al				
	Regist		DEC 2 1 2005	Alle a	1.	6000	Sec.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:55 AM Catherine Walton December 20, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Eastpoint Nursing Home Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F 77 Director 213-26-5854 January 12,1928 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 7 is marked other than "natural", or Iteme 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Yes 2 XNo MD Baltimore Dundalk Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1914 Tyler Road 21222 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 7 years Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008. Be Robert Jarrell Virgie Shifflett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James D. Walton Sr. Son 1914 Tyler Road, Dundalk, MD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, MD. 4 □Donation 5 □Other (Specify) 23,2005 Connelly Funeral Home Of Dundalk, P.A.

Connelly Funeral Home Of Dundalk, MD. 21222 21. Signature of Fune al Service License rom 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. on the enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. elst only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular AthenselenTic **Physician** /Medical Due to (or as a consequence of): Examiner Senile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician by Physician/Medica IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 🗌 Yes 1 ☐ Yes 2 No neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30641 December 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt).

Ramesh Sabapath 2ti-109 Back River Road NOCK Kamesh Sabapath

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

			For Stata Registrar	State of N	Maryland		artmen			and M	_	giene Rag. No.	005	And the second	54
		2	1. Decedent's Name (First, Middle, La	st)							2. Date of De		Yes	3. Time	
	Physicia /Medic		Thoma	s Charle	s Gordo	n Wag	ner				Decemb	er I3	3, 200	55 2:35	Ам
	Examin		4a. Facility Name (If not institution, give				4b. City,		Location o				ounty of De		
*.			201 West Montgon			4 hintholous	If I Inder	Rock	cvill		9 Date of Bin		lontgo		or Corrier
	Funeral Director			1 M 2 □ F	Age <i>(In yr</i> s. <i>Ia</i> si 89	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da January	y Year) 9. 191		Birthplace (State Country) nnsylva	
			Usual Residence of Decedent												
	how		10a. State 10b. County		10c. City, T	fown or Lo	cation							10d. Inside	•
	e Ma 3a-1 a	cto	Maryland Montg	omery	Roc	kvil								Tit	s 2□No
	vith th	Dire	10e. Street and Number				10f. Zip					_	on of What		
	s 23e	era .	201 West Montgon	12. Was Decede		13	Was Dooo	2085		ain? (Spe	cify Ves or No		ed St	merican Indian,	
_	ter de Itam	Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married	Armed Force	s?	13.	If Yes, spec	rfy Cuba	n, Mexican	, Puerto F	cify Yes or No Rican, etc.)		Black, W		
200	urs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 Yes	2 <b>∑</b> No	Specify:			S	pecify: [	Vhite	
2-0	be filed within 72 hours after death with the Maryland ital Hygiene. I death then "natural", or itams 23a or 28a-f ahow id other then "natural", or itams 23a or 28a-f ahow avant. It e Modical Excriming to ust be continued at	Completed	15. Decedent's E (Specify only highest gr		1	16a. Dece	dent's Usua kind of wo	i Occupa	ation Ju <i>rina m</i> osi	t of workin	na	16b. Kind	of Busine	ss/Industry	
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of wor DO NOT us		)		9	77 •			
2	filed within Hygiene. other than "		17. Father's Name (First, Middle, Las			Proi	essor		18 Mothe	r's Namo	(First, Middle		versi	ГСУ	
anc	I be find had be ad of	Be o	James John Wagne								ise Go		amamo,		
Maryland 21215-0036	should be fand Mental Band Mental Band Mental Bandado	ပ	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Number		Town, State	a, Zip Code)	
	and 2 :		Rita Marron Wagne	er/ Wife	00	201 W	lest M	lonte	gomer	y Ave	enue, R	ockvi	.11e,	Marylar	d 20850
Jre,	of Hee of Hee itam otha		20a. Method of Disposition	70		e of Dispo	sition (Nan	ne of ther place	e)	Dec.	ate 15	20c. Loca	ation - City	or Town, State	
E	Pages nent of ant: If it ary or o		1 ☐ Burial 2 🛣 Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Speci		119	-	Cremato			200		Beth	esda,	Maryla	nd
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or othar traumatic ones.	and Artic	21. Signature of Fune Al Service Dice	not	M013	05 30	0 West	Mont	gomery	Aven		ville,	lle, I Maryl	nc. and 20850	-2805
п	Spr. C		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause on each	sed the death.	Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	Pulr	nonary :	Fibro	sis							Onset and	ar
	/Medical Examiner		resulting in death)	Due to (or	as a consequer	nce of):									
		-	Sequentially list conditions,	b. — Qualto for	as a nonséquer	rine offi									
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,										
Ć,	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or	as a consequer	nce of):									
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ف	ng ph	Med	IF FEMALE:	-			-					- T			
Вох	death certificate be executed e attending physician and od for use as the burial-transi	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3[	Ectopic pr					23	d. Date of o	delivery Day	Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnani 9☐ Unknowr	t at time of deat n	in 5L	Other (sp	өсіту)							
P.0	The law requires that the de tte has been signed by the a rage 2 should be detached 1		Part II. Other significant conditions	contributing to deat	h but not resulti	ng in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco use	e contribute	to the cause of	death?
g	uires sign Ild be	d by	Hypertension, At	rial Fib	rillati	on					1 🗆 '	Yes 2፟X	No 3□	Probably 4	Unknown
00	w require s been si should b	Completed									24a. Was		24b. Were	autopsy finding	s available
Re	The fav te has age 2	E O					. '				autor perfo	rmed?	death	to completion of ? 'es 2 □ No	Cause of
ţa	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?								(Check only o	one)			
× ×	Physic this ceral direct	일	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpa			nt 3 DC				ne 5 <b>I</b> Resi			pecify)	
U C	Attanding Physician: if death. actor: After this certifica by the funeral director. I	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28 Da <i>y Year)</i>	8b. Time o Injury		8c. Injury Work			8d. Describe	how injury	occurred		
Division of Vital Records,	or Attanding lafter death. Diractor: After in by the funer	icat	2 Accident investigated 3 Suicide 6 Could not	De Diana of	Injury - At home	e farm st	M reet factors		Yes 2□	-	28f. Location (	Street and	Number or	Rural Route Nu	mber.
<u>≤</u> .	lor A after Dirac Jin by	Certification;	4 Homicide determined	building,	etc. (Specify)	0, 141111, 00	001, 140101	, 011100			City or To				
	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funaral Diractor: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Cartifying P	hysician: To the be	est of my knowle	edge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the	cause(s) a	nd manner	as stated.	(-)
	he Hc in 24 ha Fu pletel	edical	(Check only 2 Madical Exa	minar: On the basis and manner		n and/or in	vestigation	, in my op	oinion, dea	th occurre	ed at the time,	date and p	lace, and d	lue to the cause	(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	1			290		number					onth, Day, Year)	
			Muty	X/ 00-				D31	839			Dece	nber	13, 200	5
11	12		30. Name and address of person who Christopher J. /D	of of pleted cause of unford, M				a Omo	τι Δτ	7.0	Rockyt	116	Mar.,1	and 208	50
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	Physici		1. Decedent's Name (First, Middle, Last)  Michael Louis Abel	11					2. Date of De Month DECEMB		i, 2ď05	3. Time of Death 6:00a. M
	/Medio		4a. Facility Name (If not institution, give stree 22 MOUNTAIN ROAD	et and number)			Town, or DYSV.	Location of Deat	n	4c.	County of Death	
	Funeral Director		5. Social Security Number 6. Sex 11 M M Usual Residence of Decedent	7. Age (In yrs. la	as <i>t birthd</i> ay) 17 Yrs.	If Under Months		If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da April			nplace (State or Foreign untry) cyland
	Maryland a-f ehow	ctor	10a. State 10b. County  Maryland Washingto		, Town or Lo Shar	psbur	.g					10d. Inside City Limits  XXYes 2 □ No
	vith the	Funeral Director	10e. Street and Number 3730 Mills Road			10f. Zip		0.0		10g. Citi	zen of What Co	untry?
	ns 23	eral	11. Marital Status 12.1	Was Decedent Ever in U.S	S. 13.	Was Dece	217 dent of His		pecify Yes or No to Rican, etc.)	0.	U.S.A. 14. Race - Amer	
020	urs efter of the standard	à	1 X Never Married 2  Married	Armed Forces? 1 ☐Yes 2ऒNo If Yes, Give Year or Dates:	1	lf Yes, spe 1 □ Yes		n, Mexican, Puer Specify:	o Hican, etc.)		Black, White Specify: Whi	
7-617	within 72 hours elter death with the Maryland ene. Then "natur"s, or items 23a or 28a-f ehow ha Modral Exeminer must be notified a	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)	on ompleted) College (1-4or 5+)	life.	dent's Usu kind of wo DO NOT u	ork done d se retired)	uring most of wo	rking	16b. Ki	nd of Business/l	industry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours elter death with the Marylan Depertment of Heath and Mental Hygiene.  Deperment of Heath and Mental Hygiene.  Importent: If Item 27 is marked other than "natur", or Items 23a or 28a-f show eny injury or other traumatic event, the Machinal Examinar must be notified at once.	To Be Co	12 17. Father's Name (First, Middle, Last) John Richley Abell		5	Ludei			me (First, Middle			1
ary	shoul and Mi e mari	1	19a. Informant's Name/Relationship (Type,					nd Number or R	ıral Route Numb	er, City o	r Town, State, Z	Tip Code)
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200	ages ant of H it: if ite y or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Sn	lace of Dispo emetery, crei nithsb	natory or our	other place	, 12/1 tory <del>12-</del>	9 <b>/20</b> 05 <del>16-05</del>		-	Maryland
Baitimore,	permit. P Depertme Importer eny injur		21. Signature of Funeral Service Licensee	Fine	23	2. Name a	nd Addres	s of Facility	ouglas i	A. Fi	iery Fur	meral Home
١	Physician //Medical Examiner upon prize pr	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to	uence of):	lation	and	thermal	injurie	\$		Onset and Death
O. Box of	Physician: The law requires that the death certifica this certificate has been signed by the ettending phiral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	⊒Ectopic p ⊒ Other (s					23d. Date of deli Month	ivery Day Year
7	quires that n signed b uld be deta	þ	Part II. Other significant conditions contrib	outing to death but not resu	ulting in the u	inderlying	cause give	en in Part I.	\ .	tobacco u Yes 21		the cause of death?
Division of Vital Records,	Physician: The law re- this certificate has bee al director, page 2 sho	Completed							10XYes	opsy ormed? 2 \Begin{array}{c} No	prior to death?	topsy findings available completion of cause of 2 No
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		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify Locuse	y)	reet, facto	ry, office		City or To	wn State	a)	ysvilk MD
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	To the within To the comple	Me	29b. Signature and title of certifier	0		29	c. License	number		29d. Da	te signed (Monti	h, Day, Year)
			Jastalfe	eef ms			0	.C.M.E.		DECE	MBER 12	2005
	∑ St	ate	30. Name and address of person who comp	32. Algistrar's Signa	iture	111		STREET	BALTIMO	RE M	ARYLAND	21201
	Regist	rar	DEC 2 1 2005	A Profesor	A Co	medi	1					

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	Physic /Medi	cal	Decedent's Name (First, Middle, La.     TELLY  As Facility News (If set institution as	R.	ALLEN	Ab City Town	posting of C - 1	2. Date of Death Month November		
	Examir Funeral Director	ier	4a. Facility Name (If not institution, given Prince George's I 5. Social Security Number 6. S 215–08–2569	Hospital Cent	cer yrs. last birthday) 28 Yrs.		Y f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 25	Prince (Par) 9. Bit C 1977 MA	
	h the Maryland r 28s-f show	irector	Usual Residence of Decedent  10a. State 10b. County  MD PRINCE  10e. Street and Number		c. City, Town or Lo	ITON		10g.	Citizen of What C	10d. Inside City Limits 1 1 Yes 2 □ No
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Madical Expriner must be notified at	Completed by Funeral Director	9624 GWYNDALE DF  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🖄 No If Yes, Give Year or Dates:		20735  Was Decedent of Hisparif Yes, specify Cuban, in 1 □ Yes 2 № No	anic Origin? (Spe Mexican, Puerto i Specify:	cify Yes or No-	S.A.  14. Race - Am Black, Whi	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vant, the Madical		15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2 TH	College (1-4or 5+)	(Give	dent's Usua! Occupation kind of work done duri DO NOT use retired)  NDYMAN	ing most of worki	ng ]	PRIVATE	·/Industry
aryland	should be fill and Mental H marked ott umatic even	To Be	17. Father's Name (First, Middle, Last, WILLIAM ALLEN  19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street and	OLA DIN			Zip Code)
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8760,	ate be executed nysicien and he burial-transit	ical Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cool  c. Due to (or as a cool  d.						
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Divisio	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	111001	At home, farm, str	M 1 ☐ Yes	/	28f. Location (Stree City or Town S	t and Number or R tate)	ural Route Number,
	tha Hoap hin 24 hou tha Funei npletely fil	Medical	(Check only 2 Medical Example)	ysician: To the best of my ninar: On the basis of exa and manner stated.	y knowledge, deatl mination and/or in	vestigation, in my opini	ion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
^	or Will	~	29b. Signature) and title of certifier	luleaus		29c. License n			vember 29	
1	Str	ate_	J. Laron Locke,  31. Date filed (Month, Day, Year)	3 Registrar's 8	111 Signature	Penn Stree	et, Balt	imore, Ma	ryland 2	1201
	Regist		DEC n 6 200	15 Mener	A Don	ME)				

Baltimore, Maryland 21215-0036

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aminer	r '	4a. Facility Name (If not institution, give s				or Location of Deat	h		ty of Death	
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eral ctor		212-06-0220  Usual Residence of Decedent	7. Age (1 39	Yrs	Months Days			ay, Year) 9, 1966	Haw	place (State or Fo Intry) 7aii
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Director		Maryland Cecil		Elkton	ı					1 □ Yes 2 🔀
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		1 - For State of Ma		artment of Health and rtificate of Death	Mental Hygien	/1115 1 1 5 Ω
ME YOU	005	Decedent's Name (First, Middle, Last)		undate of Boats	2. Date of Death	3. Time of Death
Physic		Anna Maen Bull-holds			December	12 2005 740 A M
/Med Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		c. County of Death
- LAGIN	er ici	12349 Huyett Lans		Honestown		Washington
Funera	1	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country)
Directo		198-32-7977 10M 2DF	84 Yrs.	World Days Trouis Will	3/9/192	1 Acrosylvania
p v		Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or Lo	ecation		10d. Inside City Limits
lanyla ehov	5					1 ☐ Yes 2 🖪 No
the N	Director	Md. Witshing tow	HAGEES	10f. Zip Code	100.0	Citizen of What Country?
or death with the Marylan teme 23a or 28a-f ehow entitles to inclified at				21740	109.0	USA
eath	Funeral	12349 Huyett LANE  11. Marital Status  12. Was Decedent E	ver in U.S. 13.		Specify Yes or No-	14. Race - American Indian,
fter deal	臣	1 Never Married 2 Married 1 Yes 2 N	2	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puel	to Rican, etc.)	Black, White, etc.
.0036 hours after death with the Maryland tural; or iteme 23a or 28a-f ehow at Exardinar must be notified at	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🗹 No Specify:		Specify: WHITE
0 8 4	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	ntkina 16b.	Kind of Business/Industry
21215 d within 7 jiene. r then "n	n di	Elementary/Secondary (0-12) College (1-4or 5-	-)	kind of work done during most of wo DO NOT use retired)		A series
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be find the pot of our	Be	17. Father's Name (First, Middle, Last)		4	me (First, Middle, Maide	1
aryland should be fill and Mental H s marked off	မ	Levi R. Buskhola	ler Maille	ng Address (Street and Number or R		baker
Maryla id 2 should th and Mer th and Mer traumatic	1	19a. Informant's Name/Relationship (Type, Print)  Levi Burkheldee Bro				reersburg Pa 17236
an and		20a. Method of Disposition	20b. Place of Dispo	psition (Name of matory or other place)	Date 20c.	Location - City or Town, State
Pages nent of I	4	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cres	matory or other place)		
Baltimore Sermit. Pages 1. Separtment of He mportant: If iten my injury or oth		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	111yers	Cemetery 12/12 Name and Address of Facility Doc 42 AS A. Free	5/2005 /10	TADAM HAU, TA
CO Per		Douglas a Jury		Douglas A. Fiery 331 Eastern Blod.	timesal Hos	itour M)
1 ×		23a. Part1. Enter the disease, or complications that caused	the death. Do not ent			Approximate
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Box eath cert attendin for use	ian	in the past 12 months?	Petal death 3	Dectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
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of Vital Record Physician: The law requir rithis certificate has been si	Completed	Conduna Disease			24a. Was an	24b. Were autopsy findings available
Ital Rec	E	Oxus dasa Press			autopsy performed?	
Vital sician: T certificat rector, pa	BeC	25. Was case referred to medical		26. Place of De	ath (Check only one)	10 100 2010
of Vita Physician: this certific ral director,	To	examiner?  Yes 2 No Hospital: 1 □ Inpatier	nt 2 ER/Outpatier	nt 3 DOA Other: Nursing	Home 5 Residence	6 □Other (Specify)
		27. Manner of Death 1  Natural 5 Pending 28a. Date of Injun (Month, Day	Year) 28b. Time o	f 20e lower of	28d. Describe how in	ury occurred
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pitai surs a eral [			L Fellowsh.		12349 Hayett	- 0
Division  De Hospital or Attend  n 24 hours after death  be Funeral Director: A  pletely filled in by the the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner stal	examination and/or in	n occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the causer urred at the time, date a	s) and manner as stated.  nd place, and due to the cause(s)
To the Hospital within 24 hours a To the Funeral I	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
6 4 5 4		> Xxxxx		D0056965		12,2005
M		30. Name and address of person who completed cause of de	ath (Item 23a) (Type.		N	
7		(1) 1	51 E. A.+			
S	tate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature			
Regis	trar	DEC 2 1 2005	in the	Acart &		

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		-	State of Maryland / Do		rtment of H		Mental Hygie	4000	41159
	Physicia	20	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		SUSAN NMN BURKHOLZ		4) C: T	Landing of Base	DECEMBER	10, 2005	
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	NSBORO	n	4c. County of Deat	INGTON
	Funeral		4 DELLA LANE  5. Social Security Number 6. Sex 7. Age (In yrs. last birth	iday)	If Under 1 Year	If Under 24 Hrs		9. Birt	hplace (State or Foreign untry)
	Director		078-34-5901 1□M 2XF 64 Y	rs.	Months Days	Hours Min.	DEC. 17,	1940 IL	LINOIS
	pu ≱ vs		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Loc	ation				10d. Inside City Limits
	Aaryla f sho	ō	MARYLAND WASHINGTON	. 200		ONSBORO			1 □XYes 2 □ No
	the result	Directo	10e. Street and Number		10f. Zip Code	ONDDORO	10g.	Citizen of What Co	untry?
	h with	a D	4 DELLA LANE		2	21713		U.S	.A.
	ems a	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi	ispanic Origin? (S n, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "neturel", or Items 23e or 28e-f show event, the Medical Executer must be notified at	by Fu	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		□Yes 2XNo	Specify:		Specify:	WHITE
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2	filed wit Hygiene ther the	Completed	1		HOMEMAKE			OWN	HOME
Maryland 21	d tal	Be	17. Father's Name ( <i>First, Middl</i> e, <i>Last)</i> JOHN BLAINE			18. Mother's Nat	ne (First, Middle, Mai ICKEY	iden Sumame)	
3	s 1 and 2 should f Health and Men item 27 Is marke other treumatic	2		Mailing	Address (Street		ural Route Number, C	lity or Town State	Zin Code)
N N	id 2 sho lth and 27 Is m						ORO, MARYL		
ē,	s 1 ar of Hea item 3		20a. Method of Disposition 20b. Place of I	Dispos	The same and the same of the s			c. Location - City or	Town, State
ltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	SBU	RG CREMA	TORY 12/	12/2005 S	SMITHSBURG	G, MARYLAND
Balti	permit. Pages Department of Importent: If it eny injury or o		21. Signiture of Fune/al Selvice Transpe		Name and Addres			NATIONAL O, MARYLA	
			23a. Part1. Enter the disease or complications that thu sed the death. Do no shock, or page failure. List only one cause on fact line.	ot ente	r the mode of dyin	g, such as cardia			Approximate Interval Between
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К	/Medical Examiner		resulting in death)  Due to (or as a consequence)	一					
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d						
ဖ	entifica ling pl	Med	IF FEMALE:					1	10-
Вох	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?    State		Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
P.O.	the de	yslo	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	0123	other (speedify)				
	s that ned b e deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in	the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	equire en sig ould b	ed b	pericardial involve	Ve	trom	- Unit	1 Xes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records,	faw re as bee 2 sho	Completed	the lung		ance	)	24a. Was an autopsy	l prior to	topsy findings available completion of cause of
<u> </u>	The cate h page	Com	9				performer	d? death? No 1□Yes	
Vita	icien certific ector	Be	25. Was case referred to medical examiner?		3CLDOA Oth	OF.	ath (Check only one)		
ot	Phys r this ral dir	- T	1 ☐ Yes 2 ☐ No ☐ I ☐ Inpatient 2 ☐ ER/Out;  27. Manner o Death 28a. Date of Injury 28b. Ti		3 DOA 28c. Injun	4   Indiality	forme 5 X Residence 28d. Describe how		cify)
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VISI	Attendi or death. ector: A by the fu	Iffice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, stre	et, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru	ıral Route Number,
ō	rs after el Dire	Certification;	Building, etc. (Specify)				Only of Young		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.	death Vor inv	occurred at the tin estigation, in my of	ne, date and place pinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
ļ	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	1	29c. License	e number	29d.	Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (7	Type, F	Print)	204		10/10/1	21740
5H	-4		Hind Hamdan, MD:	11	30 01	PAL	1. Ha	genstow	n, MO
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature		,		/	J	
	Regist	001	Therew J.	14	afe				

		1	For State Registrar			f Marylar	nd / Depa		of H	lealth a	and M	-			1, 1	160
13			Decedent's Name (First, Middle	, Last)								2. Date of D	eath			me of Death
Phys			Idamae	Box	nen	berg.	er					Decemb	Day	8 700	5 0	9:40 AM
Exan	dica nine	A	4a. Facility Name (If not institution	, give stre	et and nur	mber)	1	4b. City, 7	Town, or	Location of	of Death	oct (mo	4c.	County of De	ath	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	1	*	Washington (	oun	ty H	ospit	al	Ha	ger	5+00	wh		W	ocshir	igtor	m
Funer	al		5. Social Security Number	6. Sex	2 <b>X</b> ) F	7. Age (In yrs.		If Under Months	Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. 8	Sirthplace (S Country)	State or Foreign
Directo	or-	-	236-18-9946 Usual Residence of Decedent	I M	ZAIF	85	Yrs.					Nov. 1		20 We	st Vi	rginia
land		-	10a. State 10b. County			10c. C	ity, Town or Lo	ocation							10d. Ins	ide City Limits
Mary -1 ah	ì	5,	W. Va.   Marsh	a 1 1			Wheeli	næ							1 [	Yes 2X No
death with the Maryland me 23s or 28e-f show	Director	2	10e. Street and Number	<u>a_1_1</u>			MILECTI	10f. Zip	Code				10g. Citi	zen of What	Country?	
h witi			636 Mozart Road					2600	03				USA	4		
	i a radiu	5	11. Marital Status	12.	Was Dece	edent Ever in U	J.S. 13.	Was Deced	ent of Hi	ispanic Ori	igin? (Sp	ecrfy Yes or N Rican, etc.)	0-	14. Race - A Black, W		ian,
IUSO ours after death with ral, or itame 23e of Express country	ű	2	1 Never Married 2 Marr		1 Tyes If Yes, Giv	2∭ No ve		1□Yes 2				,		Specify:	, 0.0.	
1 5-UU36 172 hours after "natural", or its	Ž	2 -	3 XWidowed 4 □ Divorced	Va Educati	Year or D	ates:	16a Dece	dogt's Have	l Ossum	ation			16h Ki	nd of Busine	White	
within 72 ene. than "naling he waster	patalamo		15. Decedent (Specify only highes	s Educati	ompleted)		(Give	dent's Usua kind of wor DO NOT us	k done d e retired	during mos f)	t of work	ing	10b. KI	riu oi ousirie	ss/muustry	
with ene.	į		Elementary/Secondary (0-12)		College (1	1-4or 5+)		teria					For	od Ser	vice	
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Tand lid be filk fental Hy rked oth tic event	9		Carter Earl Ric	hards	on					Myra	a Anr	Burke	nhave	er		
and N	1		19a. Informant's Name/Relations	hip <i>(Type</i> ,	Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Numb	er, City o	r Town, State	a, Zip Code)	
and 2 si and 2 si ealth an n 27 is i			Dolf Bonenberge	r - S	on		7403	Zoar	Va1	ley R			gvil:	le, Ne	w Yorl	14141
ges 1 an it of Heal	i		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 □Rem	oval from	1	Place of Dispo cemetery, cre-	osition (Nam matory or ot	e of her plac	e)		Date	20c. Lo	cation - City	or Town, St	ate
altimor mit. Pages partment of cortant: If it	1		4 □ Donation 5 □ Other (S				. Zion				2/14			eling,		a.
Baltimore, permit. Pages 1 a Department of Hea Important: If Itam any injury or othe	DCe		21. Signature of Funeral Service	Licensee	-		100	2. Name and			3870	nnich				
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Physicia ate be executed  Wedici Examine hysicien and the burial-transit	al er	וכמו באמ	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	a b c d	Due to	(or as a consector of a consector of as a consector of a consec	quence of):								0.130	t and Death
BOX 68/ leath certificate attending phys	/ARD		IF FEMALE:	23c.	If ves. out	tcome of pregr	nancv							23d Data of	doliron	
HECOTIS, P.O. BOX 58  The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	hy Dhyeloles/Med	yalcıdı	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	200.	1 Live b	oirth 2 ∏ Fet nant at time of	al death 3	_Ectopic pre_ _Other (spe		,				23d. Date of Month	Day	Year
s that ned b	à	L /	Part II. Other significant condition	ons contrib	outing to d	leath but not re	sulting in the u	inderlying ca	ause give	en in Part I	l.	23e. Did	tobacco u	ise contribute	to the cau	se of death?
w requires to been signed should be a								_				1 🗆	Yes 2	□No 3□	Probably	<b>X</b> □Unknown
Hecords, he law requires t a has been signe ige 2 should be	1											24a. Wa	s an	24b. Were	autopsy fin	dings available
	0	5										perf	ormed? 2 No	death		
VITAL ilcien: T certificat rector, pa	0	ו	25. Was case referred to medical examiner?	_							e of Deat	h (Check only	one)			
Of \ Of \ Physic ruthis countries of the standard of the stand			1 ☐ Yes 2 No			Inpatient 2				4 🗔 140	ursing Ho	me 5 Res			pecify)	
On Conding Figure 1. After funeral	9	5	27. Manner of Death 1 X Natural 5 ☐ Pendin	g	28a. Date (Mon	of Injury ith, Day Year)	28b. Time o Injury	M 2	Bc. Injun Worl	yat k? Yes 2	No	28d. Describe	now injur	y occurred		
DIVISION If or Attending after death. Director: After d in by the fune	100	Cal	2 Accident investig	not be	28e Place	e of Injury - At I	home farm st			165 2	140	28f. Location	(Street an	d Number or	Rural Rout	a Number
DIV el or A s after al Dire	000000000000000000000000000000000000000		4 Homicide determ	inea		ing, etc. (Spec		oot, tactory	, 611100				wn, State			
DIVISION OT VITA  To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	) locitori		29a. Certifier 12 Certifyir (Check only one)	g Physici Examiner	: On the b	e best of my kn basis of examin nner stated.	nowledge, deal nation and/or in	h occurred a vestigation,	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	cause(s) , date and	and manner I place, and o	as stated. fue to the ca	ause(s)
To the within 2 To the complet		Ä	29b. Signature and title of certified					29c	Licens	e number	_/		29d. Dat	te signed (Mo	onth, Day, Y	ear)
1			· AMO	09				$\Box$ $D$	00	530	//		Pa	CEUB	200	,200
1H-2			30. Name and address of person	who comp	leted caus	1 1	PIA		ark	Baran	nt	Tores	Un	or L.	M °	, 2005 2740
	Stat		31. Date filed (Month, Day, Year)	NIG 1	3P. F	Registrar's Sign	ature	offico	1	-1 E./	PN1.(	Jenney,	1128	MINICIPA	,100	4/40
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		1 _ For State	State of Marylai				ental Hygi	e <u>p</u> e005	4161
		Registrar		Cel	tificate of I			g. No.	
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Ma:-y  L	Bottner			A	Date of Death Month	Day Year 4 2005	3. Time of Death 18:38
Examir	ner	4a. Facility Name (If not institution, give s	: 11 1 1	1.1.	P 1/2	Location of Death		4c. County of Dea	th
	× .	5. Social Security Number 6. Bex		( lufe)	If Under 1 Year	If Under 24 Hrs.	Date of Birth	9 Bir	tholace (State or Foreig
Funeral Director			<sup>M 2</sup> ₩F 67	Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, March 27	7,1938 Ma	thplace (State or Foreig buntry) ryland
yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limit
e Mar	ctor	Maryland Anne Aru	ndel	David	sonville				1 ☐ Yes 2 <b>X</b> ]N
ith th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
sath v s 23s	rai	3526 Queen Anne B		16 1121	21035		fu Van as Na	USA 14. Race - Amo	nican Indian
in 72 hours after death with the Maryland in 72 hours after 23a or 28a-f show Indical Exercitival rithal by ricilified at	by Funeral Director	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	f Yes, specify Cuba	ispanic Origin? (Specin, Mexican, Puerto Ri Specify:	can, etc.)	Black, Whi	
n 72 n 72	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of working ()	1	6b. Kind of Business	/Industry
d within giene.	EO	12th	College (1-401-3+)	Но	memaker			Home	
	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (	First, Middle, M	aiden Sumame)	
Inial ylalla d 2 should be file th and Mental Hy 77 Is marked oth traumatic event	2	Clarence R. Mo					rginia		
2 sh and 1 sm		19a. Informant's Name/Relationship (Ty)				and Number or Rural			
s 1 and f Health itam 27 other tr	1	Frederick A. Botts 20a. Method of Disposition						IVICSONVII  Oc. Location - City or	le MD 2103
Page ment o ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	dilloval from State	_	sition (Name of natory or other place Cemeter			Davidsonvi	
Deficient Page Department of Important: If any njury or once.		21. Signature of Funeral Service Line has	-			ons Island			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	rascula	er the mode of dying the mode of dying the control of the control	, ,		clussion	Approximate Interval Between Onset and Death
g physicien and as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse				/		,
death cert a attendin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 V 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	tal death 3[	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
signed b	by P	Part II. Other significant conditions con	- 1- 1	4.7		2 /	23e. Did toba	acco use contribute t	o the cause of death?
w require been signature should to	ed	Hypertension Hy	pertipidemia	Atı	ral fibi	illation	1 ☐ Yes	s 2 □ No 3 □ P	robably 4 Unknow
hes 162	Completed	Viebetes mellific	<i>'</i>				24a. Was an autopsy perform	prior to	utopsy findings availat completion of cause of s 2 \sumbox No
ysician: Thysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	-		
Physician: this certific ral director,	ို	1 ☐ Yes 2 No		☐ ER/Outpatier		4   Nursing Home		nce 6 □Other (Spe	ecify)
Attending Ph r death. ector: After th by the funeral	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at 28 k? Yes 2 □ No	d. Describe how	w injury occurred	
Hospital or Atten 24 hours after deat • Funeral Director: letely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office	28	If. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
To the Hospitat or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my knoer: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, ar pinion, death occurred	d due to the car I at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	,	^	29c. Licens	e number	29 A	d. Date signed (Mon	th, Day, Year)
		30. Name and address of person who co	empleted cause of death (Ite	MJ)	Print)	15886		ecomber 4	1 2005
		Bradley Robotton	MD 22	5. GHE	ene Street	et Balti	more,	MD ZI	201
St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	mode 1				

		•	1 - For State of I	Maryland / Depa	artment of Hertificate of D		ental Hygie	ZUUG	4116	52
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of D	Death
	Physicia /Medic		WILLIAM FRANCIS BLACK		r		DECEMBER	6, 2005	6:58	<b>A</b> <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Death		4c. County of Death		
			1335 CALVERT ROAD  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	CHESTER  If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	QUEEN AN		Foreign
В	Funeral Director		216-14-2458 ¹™™ 2□ F	88 Yrs.	Months Days	Hours Min.	(Month, Day, Ye JAN. 14,	1917 DE	place (State or intry)	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City	/ Limits
	Maryl f sho	io	MD QUEEN ANNE'S	CHESTER					1 Tes 2	2 <b>X</b> ] No
	r 28a	Irec	10e. Street and Number	VIII Z	10f. Zip Code		10g.	Citizen of What Cou	intry?	
	th wit	alD	1335 CALVERT ROAD		21619		U	SA		
	be filed within 72 hours after death with the Maryland Ital Hyglene. Id other then "natural", or Items 23a or 28a-f show event, the Medical Examinat included at	Funeral Director	11. Marital Status 12. Was Decede Armed Force	s?	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
36	rs afte	by F	1 ☐ Never Married 2 Married 1 M Yes 2:  1 ☐ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 <b>X</b> No	Specify:		Specify: W	HITE	
21215-0036	2 hou atura	ted	15. Decedent's Education	1943 16a. Dece	dent's Usual Occupa	tion	16b	. Kind of Business/li	ndustry	
215	within 7 ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	life.	kind of work done d DO NOT use retired)	uring most of worki	ng			
	e filed within al Hygiene. I othar than ' vant, I'le Ma		9	PLAN'	r supervis			RANSPORTA	TION	
Maryland	Ibe fill ntal H ad oth	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	ien Sumame)		
2	should be and Menta a markad umatic ev	2	ROLAND BLACK  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	CLEO MAR		ty or Town, State, Zi	p Code)	
Ma	nd 2 g lith ar 27 is r trau		BLANCHE VERNICE BLACK/WIE		CALVERT I			21619		
ore,	es 1 an of Heal fitam 2 r othar		20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other place	e) [		. Location - City or T	own, State	
<u>i</u>	Pages nent of ant: If it ury or o		1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CHESAPEAK CENTER, I	E CREMATI	ON 12/07	/2005 S	TEVENSVIL	LE, MD	
Baltimore,	permit. Pag Department Important: t any Injury o		21. Signature of Funeral Service Licenses		2. Name and Address ELLOWS, HI D6 SHAMROO	ELFENBEIN CK ROAD,	CHESTER,	FUNERAL MD 21619	HOME, P	.A.
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent h line.	ter the mode of dying	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	vie 0651	rue 1146	10/mon	KAJ DISE	ASL	Onset and De	atn .
	/Medical Examiner		resulting in death)  Due to (or	as a consequence of):	+ Fal	11/0				
	Ξ	er		as a consequence of):	CI 1171	016			-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Tens, an						
o,	ate be executed hysician and the burial-transit			as a consequence of):						
8760,	ate be	lical	d							
9	- L S	Physiclan/Med	IF FEMALE: 23c. If yes, outco	me of pregnancy	<del>_</del>			23d. Date of deliv	· · · · · · · · · · · · · · · · · · ·	
Box	eath certif attending I for use a	clan	23b. Was decedent pregnant 1 Live birth	n 2 🗍 Fetal death 3 🛭	Ectopic pregnancy Other (specify)			Month Month	•	ear
o.	that the di ed by the detached	hysi	9 ☐ Unknown 9 ☐ Unknow	n						
S, D	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to deal	h but not resulting in the u	inderlying cause give	n in Part I.		co use contribute to		
ord	w requir been si should		FACTOR VIII DESCRIP				1 Tes	2 □ No 3 <b>□</b> /Pro	bably 4 Un	iknown
Records,	e law r has be je 2 sh	Completed					24a. Was an autopsy performed	/ prior to c	opsy findings av ompletion of cau	vailable use of
E F	Th ate pag						1 Yes 2 🗹	No 1 ☐ Yes	2 No	
Vital	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inp	atient 2 ER/Outpatier	nt 3□ DOA Othe	26. Place of Death		e 6 ☐Other (Spec	(6.)	
of	g Physier this ieral di	-	27. Manger of Death 28a. Date of	njury 28b. Time o	IL SUDON	4   Nursing no	28d. Describe how i		ny)	
ion	한 옷을 밝	atlo	1 Matural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury		r res 2 □ No				
Division	or Atta	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	Injury - At home, farm, str, etc. (Specify)	reet, factory, office		28f. Location (Street City or Town, S.	t and Number or Rui tate)	al Route Numbe	er,
٥	urs af	O						( )		
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	dical	29a. Certifier (Check only one)  Certifying Physician: To the base and manne	s of examination and/or in						
	To the within 2 To tha comple	Me	29b. Signature and title of Sprtifier	10. 0	29c. License	200		Date signed (Month		
)			Jel Nuriner	m.)1.11.	027	055	1.	4/1/05		
	101/1		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)	1 10.7	0,01	Care	11/11.4	12
	UIL		31. Date filed (Month Per Kear) 7 200 32. Re	strar's Signature	04 1416616	AI LENIC	Ra.	UKNIGNUL	110/149	J1638
	Sta Registi		DEC 7 2005	of death (Item 23a) (Type,  My J  Strar's Signature	frede					

		For State Registrar	State of Ma	ai y lai la			e of D		Menta	Reg. N		5 1110	
Physici	20	1. Decedent's Name (First, Middle, Last	)						Mont		ay Ye		
/Medic		Elias B. Barban					_				2, 200		
Examin	er *	4a. Facility Name (If not institution, give Holy Cross Hospit				S	ilver	ocation of Dea. Spring	ſ		c. County of D Montgo		
Funeral Director		5. Social Security Number 6. Se 215-58-8840	7. Ag M 2□F	e (In yrs. lasi 83	Yrs.	If Under Months		If Under 24 Hr Hours Mir	. (Mon	of Birth th, Day, Year 8, 1	7 1	Birthplace (State or Fore Country) Palestine	
		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limit		
ol b	5											1 □ Yes <b>2</b> X□	
a or 28a-f show	ect	Maryland Montgor  10e. Street and Number	nery	wite	aton	10f. Zij	D Code			10g. C	itizen of What	Country?	
23a or	<u> </u>	11911 Dalewood Di	cive				0902					USA	
or items	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 XIII Yes, Give Year or Dates:		If	Vas Dece Yes, spe	cify Cuban	panic Origin? ( , Mexican, Pue Specify:	an, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: White	
"natur	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		l 6a. Decede (Give k life. D	kind of wo	al Occupat ork done du ise retired)	ion Iring most of w	orking	16b.	6b. Kind of Business/Industry		
then "u	ma	Elementary/Secondary (0-12) 4	College (1-4or	5+)			inter				Automobile		
ital Hygiene. od other than event, I've Mu	0	17. Father's Name (First, Middle, Last)						18. Mother's Na	ame (First, M	liddle, Maide	n Sumame)	<u></u>	
1 1 7 0 e	To B	Bandali Barbari						Olomb	i Kaya	al			
Health and Mental I		19a. Informant's Name/Relationship (7) Badia E. Barbari/				_		Drive,				e, Zip Code) d 20902	
t of Health a		20a. Method of Disposition  1 \( \mathbb{\text{S}}\mathbb{\text{Burial}} \) 2 \( \mathbb{\text{Cremation}} \) 3 \( \mathbb{\text{I}} \)	Removal from State	20b. Plac	e of Dispos etery, crem	sition (Na natory or	me of other place,	Dec	Date ember	6, 20c. I	Location - City	or Town, State	
Department of the properties o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License		Gate	of Heav	rane.	nd Addiess	Collin.	:005 .s Fune	eral H	ome Ind	pring, Mary C	
20 5 5 8		James 56	and of		50	00 Uı	niver	sity Bl	.vd, W	. Silv	er Spr	ing, MD 209	
xaminer and the burial-transit	ai Examiner												
ite has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3 🗌	Ectopic p	oregnancy pecify)				23d. Date of Month	delivery Day Year	
signed b	۵	Part II. Other significant conditions or	ontributing to death b	ut not resulti	ng in the un	iderlying (	cause giver	n in Part I.	23e.			e to the cause of death?  Probably 4Unkno	
	Completed									Was an autopsy performed?	prior	a autopsy findings availate to completion of cause h? Yes 2 \[ \sum \text{No} \]	
certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place of D					
this ral di	T.	1 ☐ Yes 2 ☐XNo  27. Manner of Death	Hospital: 1 XInpati 28a. Date of Inju	ent 2 EF	VOutpatient			4 Nursing		Residence		Specify)	
Atte	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	y Year)	Injury	М		es 2 No			•	0.7/0		
2 2 2	Certifi	4 Homicide determined	289. Place of in	ury - At home c. (Specify)	e, farm, stre	et, factor	ry, office			ition (Street a or Town, Sta		r Rural Route Number,	
rs afte rai Dir			sician: To the best iner: On the basis of and manner st	f examination									
24 hours afte Funeral Dir	edic	31107				29	c. License	number		29d. D	ate signed (M	onth, Day, Year)	
	Medical	29b. Signature we title of certifier		1	1	1177	-		-		. /	1	
24 hours afte Funeral Dir	Medic	29b. Signature we title of certifier	i. Wil	we,	ad	1177	-	619	37		2/3	1	
24 hours afte Funeral Dir	Medic	29b. Signature we title of certifier	completed cause of	death (Item 2	За) (Туре, Г	Print)	Doe	619				8/05	

**Space of the control of the contro	9. Birthplace (State or Foreign Country) Washington, DC  10d. Inside City Limits 1 Yes 2 No  Vhat Country?  A.  a - American Indian, k, White, etc White  Isiness/Industry  al Car  (e)
Suburban Hospital  Hoder I Year   Hunder 1 Year	9. Birthplace (State or Foreign Country) Washington, DC  10d. Inside City Limits 1 Yes 2 No  Vhat Country?  A.  a - American Indian, k, White, etc White  Usiness/Industry  al Car  (e)
Second   Security Number   Second   Second   Security Number   Second   S	9. Birthplace (State or Foreign Country) Washington, DC  10d. Inside City Limits 1 Yes 2 No  What Country?  A.  a - American Indian, k, White, etc. White sisiness/Industry  al Car  (e)
Sept. 2, 1920   Sept. 2, 192	10d. Inside City Limits 1 Yes 2 □ No  What Country?  A.  a - American Indian, k, White, etc White sisiness/Industry  al Car  (e)
10a. State   10b. County   10c. City, Town or Location   20906   10g. Citizen of North International Number   10d. Street and Number   10d. City or Down   10d. City	No 1 H Yes 2 □ No  What Country?  A.  a - American Indian, k, White, etc White sisiness/Industry  al Car  (e)
15.107 Interlachen Drive, Apt. 709   20906   U. S.	No Note that Country?  A.  a-American Indian, k, White, etc.  White sisiness/Industry  al Car
15107 Interlachen Drive, Apt. 709   20906   U. S.	A.  a-American Indian, k, White, etc. White siness/Industry al Car
15107 Interlachen Drive, Apt. 709   20906   U. S.	a-American Indian, k, White, etc. White siness/Industry al Car
Specify   Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired)   16b. Kind of Bridger   Specify   Spe	k, White, etc. White sisiness/Industry  al Car
Specify   Spec	White siness/Industry al Car
15. Decedent's Education   16a. Decedent's Usual Occupation   16b. Kind of Brown properties	al Car
David Brill  19a. Informant's Name/Relationship (Type, Print)  Gary B. Brill - Son  20a. Method of Disposition  1	al Car
David Brill  19a. Informant's Name/Relationship (Type, Print)  Gary B. Brill - Son  20a. Method of Disposition  1	6)
David Brill  19a. Informant's Name/Relationship (Type, Print)  Gary B. Brill - Son  20a. Method of Disposition  1	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	State, Zip Code)
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  1091 Rockville Pike, Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville Pike, Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville Pike, Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville Pike, Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville Pike, Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville Pike, Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  11091 Rockville, Management of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of the mode of dying, such as car	State, Zip Code)
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tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between
resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Cause (Disease or injury that initiated events c. Due to (or as a consequence of):	
The state of the s	
IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy	e of delivery
in the past 12 months?  1   Yes 2   No 9   Unknown    Unknown    Unknown    Unknown    Unknown	nth Day Year
1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown 23e. Did tobacco use cont	ribute to the cause of death?
8 6	3 ☐ Probably ♣ ☐ Únknown
24a, Was an 24b, V	Vere autopsy findings available
Q Q autonsy	prior to completion of cause of death?
0 25. Was case referred to medical axaminer? Hospital: Cther:	☐ Yes 2☐ No
1 Vinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Oth	ar (Specify)
	od :
2 12 10 10 10 10 10 10 10 10 10 10 10 10 10	Karre
29a. Certifier    Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.    Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.    Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.    Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.    Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and manner stated.    Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.    Certifying Physician: To the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	
Interlaci	
29a. Certifier  Cineck only  and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	nen Dr.Apt.709
28. Place of Injury: At home, farm, street, factory, office  4 Homicide  28. Location (Street and Numb City or Town, State)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma manner stated.  29a. Certifier  29a. Certifier  29b. Signature and the excertifier  29c. License number  29d. Date signer	nen Dr.Apt.709
8 230 Signatura and the season of the come) 250 States and the season of the come of the c	nner as stated. and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nner as stated. and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QIKE, BOCKNEW, MO 20852	nner as stated. and due to the cause(s)
State 31. Date filed (Month, Day, Year) DEC 0 6 2005	nner as stated. and due to the cause(s)

			•	State of N State Of N Registrar	/larylan			f Health and of Death		ene 9. No.2 (1 (1 5	1.1166
		Physici	an	1. Decedent's Name (First, Middle, Last)  Doorpatee Baron					2 Date of Death Month December	Day Year	3. Time of Death
		/Medio Examin		4a. Facility Name (If not institution, give street and numbe Suburban Hospital	r)		4b. City, Tow Beth	n, or Location of Deat		1 2005 4c. County of Dea	ath
		Funeral Director		5. Social Security Number 6. Sex 7. A 2 1	Age (In yrs. I	last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Birth (Month, Day, March 7.	Year) 9. Bii	rthplace (State or Foreign ountry)
		pu *		Usuel Residence of Decedent  10a, State 10b. County		y, Town or Lo	cation		march /,	1943   Gu	yana 10d. Inside City Limits
		death with the Maryland ms 23a or 28a-f show rmust te nutilled at	ctor	MD Montgomery			Germa	ntown			1 ☐ Yes 2 No
		with the	Funeral Director	10e. Street and Number			10f. Zip Cod		10	g. Citizen of What C	·
		ne 23e	erai	13522 Niagara Falls Court  11. Marital Status  12. Was Deceder Armed Forces	nt Ever in U.	.S. 13.	Was Decedent	20874 of Hispanic Origin? (S Cuban, Mexican, Puen	Specify Yes or No-	United S	erican Indian,
1	920	after or its	by	1 Never Married 2 Married 1 Yes, Give 1 Widowed 4 Divorced Year or Dates	ΧNο			Specify:	to Hican, etc.)	Specify: Ea	st Indian
-	Maryland 21215-0036	within 72 hours ene. than "natural", he Madical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40	or 5+)	16a. Deced (Give life.	dent's Usual Od kind of work do DO NOT use re	ccupation one during most of wo stired)	rking	6b. Kind of Business	s/Industry
K	21	led wit ygiene ygiene her the		8	,		Homema	T	(5" 14"-41- 14	Own Hom	e
lared	/land	uld be fil Mental H srked ott	To Be	17. Father's Name (First, Middle, Last)  Mohabir				Sund	me (First, Middle, M ri	aiden Sumame)	
La	Man	nd 2 sho lith and I 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Patrick Baron/Husband				reet and Number or Ri ra Falls C		•	
B	Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avent. The Magnee.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	, C	Place of Dispo semetery, crer ce OF H	sition (Name o natory or other leaven	place)	mber 8	Oc. Location - City o	
ME	Balti	permit. P Departm Importer sny injui		21. Signature of Funeral Service Lieensee				ddress of Facility D	eVol Fune	ral Home,	10 East
L 105		Physician and // // // // // // // // // // // // //	ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	line.	aficuence of):		exing, such as cardia			Approximate Interval Between Onset and Death
(2) — (3) —	O. Box 6	certific nding p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100 9 □ Unknown  23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	Ideath 3 [	Ectopic pregna Other (specif)			23d. Date of de Month	blivery Day Year
	ds, P.	vrequires that the debeen signed by the should be detached	þ	Part II. Other significant conditions contributing to death			nderlying cause				o the cause of death?
RPA	Vital Records	The lav	Completed						24a. Was an autopsy perform	ed? prior to death?	
Ø	V Ita	ysician: is certific director,	Be C	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	-tit 0 G	ER/Outpatier		Other	ath (Check only one		
8	on of	ding Ph h. Alter th funeral	ition: To	27. Manner of Death 1		28b. Time of Injury	28c.	liniury al Work? 1 ☐ Yes 2 ☐ No	dome 5 Resider 28d. Describe how		ecity)
PARCON,	Division	al or Attendi s after death. I Director: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory, off	ice	28f. Location (Stre City or Town,	eet and Number or F State)	lural Roule Number,
PAR		To the Hospital or At within 24 hours after or To the Funeral Diecc completely filled in by	Medical C	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the be sais and manner	of examina	wledge, death tion and/or in	h occurred at the vestigation, in r	ne time, date and place my opinion, death occi	e, and due to the cau urred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
السيا	,	To the within 2 To the complet	Me	29b. Signature and lith of certifier	1			ense number		d. Date signed (Mon	,
		3	0.00	30. Name and address of person who completed cause of	f death (Item	n 23a) (Type,	Print) O M	059240 ery Gisell	e M.D.	12-01	20814
				4416 East West		chusa	y Jui	He 410	Bethes	da, MD	20814
		Sta Registi		31. Date filed (Month, Day, Year) 32/Regi	strar's Signa	aure	auti				

			For State	-	partment of Health and M	ental Hygien	1e2005 1.11CC
	40		Registrar		ertificate of Death	Reg. N	
н	Physici	an	1. Decedent's Name (First, Middle, La:	-		Month D	Day Year 3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Location of Death	11 6	Ac. County of Death
	Examin		C- 1.	11=	SALISBURG	,	WICOMICO
	Funeral		5. Social Security Number 6. S		y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		221-54-0569	□M 2 F 50 Yrs.	Months Days Hours Min.	(Month, Day, Yea 4-28-	55 Country) VA
	D		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or	Location		10d. fnside City Limits
	sho	5	24.		DLISBURY		1 <b>V</b> /es 2 □ No
	the Marylar 28a-f show	Director	10e, Street and Number	mico St	10f. Zip Code	10g. C	Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show		523 ALABAM	D AVE	21804		USA
	Items 2:	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Spe ff Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,
9	ours after death with the Maryla el', or Items 23a or 28a-f shov Executre coust by mulfited at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give	1 Yes 2 No Specify:	nicari, etc.)	Black, White, etc.
003		d by	3 Widowed 4 Divorced	Year or Dates:			Specify: BLACK
15-	_ 2 30	iete	15. Decedent's Ed (Specify only highest gra	de completed) (Gi	cedent's Usual Occupation ve kind of work done during most of worki v. DO NOT use retired)	ng 16b.	Kind of Business/Industry
21215-0036	be filed within ital Hygiene. Id other then "event, Ital Max	Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	ISABLED		NONE
	e filec Il Hyg othe	BeC	17. Father's Name (First, Middle, Last,	\		(First, Middle, Maide	en Surname)
/lar	2 should be filed and Mental Hygis Is marked other eumatic event, II	2	WILLARD	WISE	EVELY	N lou	INSEND
Maryland	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (	1 1000000	illing Address (Street and Number or Rura		22 2 101 1
	s 1 and of Health Item 27 other tr		WILLIAM H. BROW 20a. Method of Disposition	N~ HUSBAND 52	BUNDAL HVE DE POSITION (Name of	GLISBURY I	Location - City or Town, State
Jor	0 0		1 Burial 2 Cremation 3	Removal from State cemetery, c.	rematory or other place)	1	4.0
Baltimore,	1 F E E		21. Sign yure of Funeral Service Licer	1.1100	22. Name and Address of Facility 72 =		EBROW ML
Ba	permit. Departitimports any inj		Mincilla	Knings !	917-11), TSARELLA S		BURY MD 21801
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not e	enter the mode of dying, such as cardiac o		Approximate Interval Between
100	Fnysician		Immediate Cause (Final disease or condition	^	rical Cancer		Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
ė	Examine.	7	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):			
	uted i insit	Examiner	cause. Enter Underlying Cause Disease or injury that initiated events				
ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transi	dicai		d			
9	entifica ling ph e as t	Med	fF FEMALE:	00-14			
Вох	eath certific ettending p I for use as	ian/	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
P.O.	The law requires that the death certific te has been signed by the ettending p page 2 should be detached for use as	by Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	o Other (specify)		90
	that the poly	y Ph	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records,	w requires been sign should be	q pe				1 ☐ Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
000	aw rei	piet				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R	The lav	Completed				performed?	death?
Vital	icien: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Death		
of \	Physic this co	2	1 ⊈ Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpat			
ou c	Jing F	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	jury occurred
Division of	Attending Physicien: r death, sctor: After this certification the funeral director,	ficat	3 Suicide 6 Could not b	6 39a Place of Injury At home form		28f. Location (Street	and Number or Rural Route Number,
Ο̈́	al or / after Dire	Certification:	4  Homicide determined	building, etc. (Specify)		City or Town, Sta	ite)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	cai (		sysicien: To the best of my knowledge, deniner: On the basis of examination and/or			
	To the H within 24 To the Fi complete	Medical	one)	and manner stated.			
	To To	=	29b. Signature and title of certifier		29c. License number HSO 497		Date signed (Month, Day, Year)
			30 Name and address of porces who	completed cause of death (ftem 23a) (Typ			
			Chris Suyor	in E Cumil	Ct. Callsbu	7 mo	21801
	Sta		31. Date filed (Month, Day, Year)	32. Agistrar's Signature	1.1.	1	
	Regist	ar	DEC 0 6	LUUD PROCESS ST. 1	J. D. D. Marcall		

Andrew Bozarth 05-08036 NJM

			For State Registrar	State of Maryland		artmen:					jiene	005	1.1167
			Decedent's Name (First, Middle, Last)							2. Date of Dea	th	000	3. Time of Death
п	Physicia /Medic		ANDREW	BOZARTH					1	Novembe:	r 28	2005	1649 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c. Co	ounty of Death	
			9601 Marston Lan			Moi	ntgo	nery	Villa			Montgo	
	Funeral		5. Social Security Number 6. Sec	ZM OFF	t birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	B. Date of Birth (Month, Day Dec. 31	Year)	9. Birth	place (State or Foreign
	Director		216-92-4602 Usual Residence of Decedent	43	113.				1	Dec.31	,196	I Ma	ryland
	land ow		10a. State 10b. County	10c. City, T	Town or Lo	cation				· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Many Lish	to	MD Montgor	merv	Mont	tgome	erv	Vill	lage				1 DXes 2 No
	h the	Director	10e. Street and Number			10f. Zip				1	l0g. Citizer	n of What Cou	ntry?
	72 hours after death with the Maryland natural; or items 23e or 28e-f show Scal Exandrer nivet be notified at	O les	9601 Marston	Lane			2	0880	5		U	.S.A.	
	r dea	Funeral	11. Marital Status	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> </ol>	13. \	Was Deced	dent of Hi	spanic Ori n, Mexicar	gin? (Spec n, Puerto R	ify Yes or No- lican, etc.)	14.	Race - Americ Black, White,	
36	or It	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes <b>2</b> ☐ No If Yes, Give		1 □ Yes 2	2 <b>⊠</b> No	Specity:			Sp	pecify:	h d d a
21215-0036	"natural", Ideal Ex	d ba	15. Decedent's Edu	Year or Dates:	16a Decec	dent's Usua	al Occura	ition			16h Kind	of Business/In	hite
15	in 72 n "na factic	Completed	(Specify only highest grad		(Give	dent's Usua kind of woi DO NOT us	rk done d se retired,	luring mos )	t of workin	g	100.11110	0.000000	addity
212	within plene. r then "	E	Elementary/Secondary (0-12) None	College (1-4or 5+)	CSS	S Cor	nmur	ity	Supp	port	Del	very	Service
ğ	be filed tal Hygir d other event, il	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Su	ımame)	
/lar	ould be Mental arked c	ToE	Donald	Bozarth					Sl	nirley	St	aples	
Maryland	2 sho and I ie ma		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Number	r, City or To	own, State, Zip	Code)
≥.	and m 27		Robin Husslage							e, NH			
0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 7	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	ternoval irom State		sition (Nan						tion - City or To	
Baltimore,	tmen tant:	١,	4 □ Donation 5 □ Other (Specify)		- 11	Fnrl			12/6/				ia, VA Home, P.A
Bal	permit. Pages 1 and 2 should be Depertinent of Health and Menta Important: if item 27 is marked any injury or other traumetic events.		21. Signatur of Funeral Service Licens	Loused	/ /								,MD20850
			23a. Part1. Enter the disease or compleshock, or heart failure. List only or	ications that caused the death. In cause on such line.	Do ent	er the mod	e of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician	8 4	Immediate Cause (Final disease or condition	Choke	Sa	ONF	Tocal	160	o (us			1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce off.					-			
	Examiner		Sequentially list conditions,	b. —									
	ed isit	al le	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice or):								
	sate be executed shysicien and the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):								
8760,	be e sicien buris	dical E			·								
687	ficate phys s the	ခ္ဓ		0.									
Вох	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance							23d	d. Date of delive	ery
ă	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat		Ectopic pr Other (sp						Month	Day Year
P.0	at the de by the d	hys	9 Unknown	9□ Unknown						,			
T.	res tha igned I be det	by P	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the u	nderlying c	ause give	n in Part I	.1	23e. Did to	bacco use	contribute to t	he cause of death?
Vital Records,	w require been sig should b		negal reep	nostabri						1 🗆 Yı	es 271	No 3□ Prot	oably 4 □Unknown
သူ	e law re has be je 2 sho	Completed								24a. Was a autops		24b. Were auto	psy findings available mpletion of cause of
		ĕ								A perfori	med? 2 🗆 No	d all ? 1 A Yes	2 No
ita	sician: The certificate hi rector, page	Be	25. Was case referred to medical examiner?	S.RG - 600-100-110-1	- 11-2			26. Ptace	of Death	Check only or		1	
of V	S 00 10	2	1⊟Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ EP	VOutpatien			4   140	ursing Hom	e 5 🗆 Reside	ence 6	Other (Specif	Scene
	ding Phi h. After thi funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury		8c. Injury Work	at (?		Bd. Describe h	ow injury o	ccurred	E . (
sio		catl	2 Accident investigation 3 Suicide 6 Could not be	1112805	UNIC		101	res 2		where	1-314	eccon 1	TOK (
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (**pecify)	- 1	,	, office		0	Bt. Location (Si City or Town	reet and N n, State)	lumber or Rura	al Route Number,
_	pital ours a orai [		29a. Certifier 1☐ Certifying Phy	sician: To the best of my knowle		one	at the tim	a data an	Z d ninon n	601 11	KU'S 12	y Ceyu	00886
	Hos 24 ho Fun etely	edical		ner: On the basis of examination and manner stated.									
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			290	. License	number		2	9d. Date s	igned (Month,	Day, Year)
	1		1/ Lleulon	he all			OCM	E		1	Novem	ber, 29	2005
	5		30. Name and address of person who co	ompleted cause of death (Item 2)	За) (Туре,	Print)	JOIL	_			v Cili	~~ · · · · · · · · · · · · · · · · · ·	, 2005
_			J. HEN WIL	re and		11	1 Per	nn St	reet	Balti	more,	Maryla	and 21201
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	0	and I							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Дау 4, Month Physician 2005 Boettinger December 6:17A. Jean /Medical 4e Fecility Neme (If not institution, give street end number)
4500 Tonquil Place b. City, Town, or Location of Deeth Beltsville 4c County of Death
Prince George's Examiner If Under 1 Year
Months Days If Under 24 Hrs. 7. Age (In yrs. lest birthday) 74 yrs. 8. Date of Birth (Month, Day, Year) July 24, 1931 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 2 □ NF 219-28-2704 Director Usuat Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Medical Examiner must be nortified at 1 ☐ Yes 2 ☑ No Maryland Prince George's Beltsville **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20705 4500 Tonguil Place United States 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 21☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: White Baltimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Robert Holman Jean Currens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara McLaughlin -daughter 13902 Westview Forrest Drive Bowie, Maryland 20720 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery12/10/2005 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Banardado Boffewardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer one year Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner ed by the attending physician and deteched for use es the buriel-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that the within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by 'scompletely filled in by the funeral director, page 2 should be detected. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Cardiac Arrhythmia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? T You ak No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 3□ DOA 4 Nursing Home 5 N Residence 6 □Other (Specify) 28b. Time of Injury 27. Magner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner styled. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 5, 2005 D22910 ho completed cause of death (ttem 23e) (Type, Print) 4700 Berwyn House Road, #100 College Park, Maryland 20740 of person MD o. Name and eddress of p Asif Qadri,

Registrar

State

31. Dete filed (Month, Day, Year)

32 Registrar's Signature

			1 ~ State Amend Item/11 Registrar	State of Man per INF 68	dand / Den 56 6/9/06	artment of h	lealth and <i>Death</i>	Mental Hy	giene Reg. No.20	05 41169
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of De Month	Day	3. Time of Death
	/Medic	cal	Elsie Bu	itler		4h City Town	or Location of Dea		er 23, 2	2005   12:30 p M
	Examin	ier	1107 Hill Rd.	street ziid Humber)		Hyatts		ui		ce Georges
	Funeral		Social Security Number     6. Se		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th v. Year)	Birthplace (State or Foreign Country)
	Director		578-20-6243	]M 224F	87 Yrs.			April 6	,1918	Washington, D.C
	land ow		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Many Befish	tor	Maryland Prince (	Georges	Hyattsv	ille				1Ã Yes 2 ☐ No
	ih the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	-
	s 23e		1107 Hill Rd.	10 Wes Deceded Su	10	2078		Canaita Van as Na		1 States
936	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23e or 28e-f show event, the Medical Examinar must be natified at	by Funeral	11. Marital Status  **Married 2   Married 3   Married 4   Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	an, Mexican, Pue	to Rican, etc.)		k, White, etc.
21215-0036	72 hor	Completed	15. Decedent's Edu (Specify only highest grad			dent's Usual Occup kind of work done		orkina	16b. Kind of Bu	siness/Industry
2	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		GOVERNI	AT NT
ה מ	12 should be filed within n and Mental Hygiene. Is marked other then " reumetic event, the Men		17. Father's Name (First, Middle, Last)		ELLEVE	TOK OF EK		me (First, Middle,		
Maryland	ld be ental ked o	To Be	Joseph Butler					Butler		
ary	shou and M s mar umet	-	19a. Informant's Name/Relationship (T	iype, Print)	19b. Maili	ng Address (Street	and Number or P	lural Route Numbe	er, City or Town,	State, Zip Code)
	2 = 2 t		Lois Terry / Daug	ghter		Hill Rd.	Hyattsv			
ore	Pages 1 ar		20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ I	1		matory or other pla		Date		City or Town, State
Baltimore,	t. Par rtmen rtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Livers			Memorial		30,2005	Suitlar	
Ba	permit. Pages Department of Importent: If i any injury or once.		23a. Part ! Enfer the disease, or comp shock, or heart failure. List only of	and MO	1 V / 3					Approximate
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	a	onsequence of):	deme	ntia			Onset and Death
8760,	cate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a c	onsequence of):					
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (s <i>pecify)</i> _	у		23d. Dati Mor	e of delivery hth Day Year
rds, P	quires that n signed b ald be deta	by	Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did t		ibute to the cause of death?  3  Probably 4 Unknown
l Records,	The law require ate has been sig page 2 should b	Completed						24a. Was autor perfo 1 Tyes	osy pormed? d	Vere autopsy findings available prior to completion of cause of leath?  Yes 2 \( \subseteq \) No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		O#	200	eath (Check only o		
o	ys di	To :	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	IL JUDON		Home 5X Resi	dence 6 Other	
on	Attending I ir death. ector: After by the funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	Wo	rk?` ]Yes 2 □No		,,	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely tilled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		reet, factory, office		28f. Location (. City or Tox		er or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Direction Completely filled in I	Medical C		ysician: To the best of n iner: On the basis of ex and manner stated	camination and/or in					
	To the Within To the	Me	29b. Signature and title of certifier	Ω		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
)			Kynnu.	) home	201 nm	DO	574	00	11 / 3	0/05
2	- (5)		30. Name and a tress of person who c LYNN A. THOMAS, M	completed cause of deat $1.D.1221$ MI	th (Item 23a) (Type, ERCANTILE	Print) LANE, U	PPER MAR	LBORO, M	0.20774-	5374
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 0 6 2005		Signature	B				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10c per fb 9850 12-19-05 vt
State of Maryland / Department of Health and Mental Hygiene 115 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Raymond Cecil Barclay 21:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cumberlano Allega salved Heart Months Days Hours Min. Reput of Birth (Month, Day, Year) Feb 7 1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace State or Foreign **Funeral** 1 XM 2 ☐ F 71 217-30-1922 Yrs Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Medical Examinar must be notified at Cresaptown -Cumberland MD Allegany 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 12823 Meadow Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1X Yes 2 No 1955 If Yes, Give Year or Dates: 1960 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: White δ 3 Widowed 4 Divorced 1960 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Housekeeping 12 of Health and Mental Hygie Item 27 is marked other rother traumatic event, it other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Estella (llewellyn) Barclay Wilson Barclay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12823 Meadow Ave., Cresaptown, MD 21502 If Item 27 is E. Darlene Barclay Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department of Important: If any injury or once. Frostburg Mem Park Dec 15 05 Frostburg, 22. Name and Address of Facility Hafer Funeral Service, 21. Signature of Funeral Service Licensee 1302 National Hwy., LaVale, MD 21502 Enter the disease, or complications that balsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final disease or condition resulting in death) **Physician** noumonia 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death Month 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ubs mictive monon 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s performed? Yes 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Parient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To ctor: After this y the funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dec 13, 2001 DO033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) DEC 1 9 2005

DR. SUNIL GUPTA



#101 Cumbercaus, ND 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005

Amend Item 26 per verb. Centificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month December 2, 2005 3:23 P. M John Dawkins Briscoe 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1XM 2□F Months Days Hours Min. Yrs. 218-16-3380 1920 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐ Yes 2X No Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20685 United States 4900 Briscoe Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X2 Yes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specity: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jeannie Parran Dawkins H. Clare Briscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4900 Briscoe Road, St. Leonard, Maryland 20685 Mary Sesson Briscoe (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Christ Epis. Ch. Cem. 12/7/2005 | Port Republic, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lices 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary antery disease day disease or condition resulting in death) Due to (or as a consquence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient X ☐ DOA 1 ☐ Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

**Examiner** The law requires that the death certificate be executed Box 68760, Caluate  $4a_1$  H. Division of Vital Records, P.O.

physician and the burial-transit Hospital or Attending Physician: this Director: thin 24 hours a

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

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other

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t Health item 27 I other tra

Department of Important: If any injury or once.

Physician

/Medical

Examiner

Physician/Medical

by

Be Completed

Certification:

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

the Medical

Directo

Completed by Funeral

Be

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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State Registrar

hanks W. Bennett M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1725156

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

December 3, 2005

Trueman Road, Lusby, Maryland 20657 Charles W. Bennett, MD 11845 H. G. 31. Date filed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 1 per doc 12-19-05 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rosalind Beckwith 11, **Physician** Month Rosalind December Beckwith 2005 6:44am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood @ Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Year Min. March 31, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1909 Kentucky Months 1 M XXF 96 352-38-9389 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-1 show er than "netural", or items 23a or 28a-f show the Medical Examinar must be notified at Maryland Frederick Frederick XX Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 750 Carroll Parkway, Apt. 70 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XIX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "netural", or iten any injury or other treumetic event. The Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: 3 

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Childress Frances McFerron ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Beckwith, daughter 619 South Stafford Street, Arlington, VA 22204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Dec. 12, 2005 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnys<del>icia</del>n 2515 /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes ¥₽ No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 Mo Be 26. Place of Death (Check only one) Hospital: Other: 0 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aff To the Funerel Di 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mahner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 12, 2005 D16428 30. Name an lad ress of lirs in who is placed cause of death (I em 23a) (Type, Print) Casper E. Cline, III, MD, 300 West Ninth Street, Frederick, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:15 P. December 11, Gerald Bowman 2005 Α. /Medical 4a. Facility Name (If not institution, give street and number) 12103 Pleasant Valley Rd. 4b. City, Town, or Location of Death 4c. County of Death Examiner Smithsburg Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 85 Yrs. Director 215-18-2883 Aug.30,1920 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be rediffed at 1 ☐ Yes 2 No Md. Smithsburg Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö or Items 23a 12103 Pleasant Valley Rd. 21783 U.S.A death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Examinations. 1 XYes 2 No 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 44-46 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Molder Tool Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleg E. Bowman Minnie V. Draper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olive G. Bowman (Wife) 12103 Pleasant Valley Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.14,05 Pleasant Valley Cem. Smithsburg, Md. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Mo1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ate nas been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 12 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1□ Yes 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and little 29d. Date signed (Month, Dev. Year) certifie death (Item 23a) (Type, Print) 30. Name and address of completed cause of P 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

		For State Registrar	State of Ma	-	epartment of H Certificate of I			ene () (	)5	41175
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and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				1	IOd. Inside City Limits
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Vagdelene 9:00 Am ,2005 ec /Medical 4b. City, Town, or Location of Death 4a Facility (If not institution, give street and number) 4c. County of Death Examiner )altimore Baltimore Hrs. 8. Date of Birth (Month, Day, Oct. 16 If Under 1 Year Under 24 7) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 215-22-2441 1 □ M 2 X F 99 Yrs. Oct. 1906 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 ☐ Yes 2 No Maryland Baltimore Baltimore County Funeral Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Herrie 23a or 8800 Old Harford Rd. 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0020 5 Completed by 3€Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Homemaker Homemaking~Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be h end Mental h Mary Stroehlein August Tormollen 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health e important: if item 27 is any injury or other trau Mrs. Geraldine Crim (Sister) 8118 Hillendale Rd. Baltimore, Md. 21234 20b. Place of Disposition (Name of comptery, cremetory or other place)
Gardens of Faith Cem. 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 12/16~05 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home /401 Belair Rd. Baltimore, Md. 21236 Xassakn 23a. Part1. Enter the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of Physician/Medical Examiner buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicompletely filled in by the funeral director, page 2 should be deteched for use as the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? Pailure 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License number autus pm 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 560 31. Date filed (Month, Day, Year) 32. Redistkar's Signature Registrar

DHMH 16 Rev 6/95

				State o	f Marylar								gible.		
			1 - For State Registrar			Ce	rtificat	e of L	Death			Reg. No:	105	4	178
100	Physici	an	Decedent's Name (First, Middle,								2. Date of De Month	Day	Year		e of Death
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-	Examir	ner	Washington Coun	-				ersto		or Dourn				ton Co	
	Funeral	Ŋ.	5. Social Security Number	5. Sex 1 <b>⊠</b> M 2□F	7. Age (In yrs.			1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di	rth			ate or Foreign
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	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Insid	e City Limits
	e Mar ta-1 et	Director	Maryland Washi	ngton Co.	138	828 Mar	sh Pi	ke		<u> </u>				1 🗆 1	Yes 2 No
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Jre,	of Health Item 27		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of			Date	-		Town, State	
<u>i</u>	Pages ment of I ant: If its ury or o		1 ⊈Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	eenhil.				c. 1	2,2005	Wayne	sboro	, Penr	nsylvan
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18	/Medical		disease or condition resulting in death)	a. Due to	or as a consec		*							911	710)
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חכ	ding P. After t	tion:	27. Manner of Death  1 Naturat 5 Pending 2 Accident investiga		of Injury th, Day Year)	28b. Time o fn <del>j</del> ury	f A	8c. Injury Work	at :? ∕es 2 🔲		28d. Describe	how injury oc	curred		
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			30. Name and address of person w	ho completed caus	se of death (Ite	т 23а) Туре,	Print) /		RSTO			10	217	112	
1 1 30	Sta	ate	31. Date filed (Month, Day, Year)	191 [F	legistrar's Sign	ature	17	MUL	1-1)	JWI	O IV	11/	211	7 -	
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DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** A M 4, 6:15 Suzanne B. Chewning December 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Millennium at South River Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗶 F Months Yrs 4, 85 1920 Ohio Jan. Director 276-10-9065 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County ust be notified at 1 ☐ Yes 2 No Directo Anne Arundel Maryland Edgewater 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1607 Havre de Grace Drive 21037 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. nnt: if Item 27 is marked other then "naturel", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene. It is marked other then "naturel", or items treumatic event, Ire Madical Examinal. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kolonick George Bezak Susan P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a importent: if item 27 is eny injury or other tree 90.00. 1607 Havre de Grace Dr., Edgewater, MD 21037 e of Disposition (Name of Date 20c. Location - City or Town, State Glenda J. Walsh/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ` 4 ☐Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 12-7-05 Silver Spring, MD 21. Signat funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aldiac disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by t d be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

The law requires that the death certificate be executed

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24 hours a e Funerei (

To the Vithin 2

Box 68760

P.O. 1

Division of Vital Records,

Physicien:

Baltimore, Maryland 21215-0036

þ Completed director, 2 funeral

Certification:

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Voluming Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🖺 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Annapolis, MD 21401

12-5-05

State Registrar

Chopia, M.D.
Jonth, Day, Vear) 32 **DEC 0 6 2005** 

nd title of certifier

29b. Signature

Auty Cho
31. Date liter (Month, Day,

32. Registrar's Signature

coo Progely

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11/28/2005 Year **Physician** 6:12 Рм Janice Rita Cresap /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/17/1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖔 F Vermont 214-36-3764 68 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "neturel", or items 23a or 28e-f ehow the Medical Examinar must be notified at XXYes 2 □No Directo Crofton Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21114 1465 Jordan Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o filed within 72 hours after de la Hygiene.

I Hygiene.

other then "neturel", or Item Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3X Widowed 4 □ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital/ NIH Nurse i. Pages 1 and 2 should be filed w thent of Heelth and Mental Hygien rient: If Item 27 is marked other ti njury or other treumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Taberski Francis Makowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2329 Blue Valley Drive Silver Spring, MD 20904 Paul Makowski/ Brother 20a. Method of Disposition

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Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cematery, cramatory or other place)
Maryland Date 20c. Location - City or Town, State permit. Pages Department of Importent: If It eny Injury or o 12/6/2005 4 ☐Donation 5 ☐ Other (Specify) Crownsville, MD Veterańs Cemetery 22. Name and Address of FacilityRobert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 1 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition a. COPD Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and I for use as the burial-transit Exam Hypertension resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 2 XER/Outpatient 3□ DOA this Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ca 29a. Certifier within 2 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017961 12/6/2005 30. Name and address of person who completed cause of feath (Item 23a) (Type, Print) 1667 Crofton Center #1, Crofton, MD 21114 Oscar Farias, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 AM aRAh 2005 SIER Man /Medical County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number, **Examiner** Nursing Lene WORCH ESTER 5. Social Security Number 6. Mood ambludge 1 Year If Under 24 H If Under 1 Year 8. Date of Birth (Month, Day, Ol-25- Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Min. 1 M 2 F 3 Months Days 0 219-07-476 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County State if Health and Mental Hygiene.
item 27 is marked other then "natural", or Items 23s or 28s-f show other treumstic event, I'v. Medical Examinar must be notified at 1 Yes 2 No ambridg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4.21 burn Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours atter deat. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" ones injury or other treumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) omEstic 6+A aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hostor avinia 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camellia ST. ambridge ND 2441

Date 20c. ocation - City or Town, State MD Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemelery 12-3-2005 Yocomo Name and Address & Facility Anthony E. Ward Funeral Hamo 10639 Hampder Are Princes: Anne 12-3-2005 Yocomoke. 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee E, Ware MD 21853 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Merosclerotic Physician 4. Ars disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if dry, leading to initial sales cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Disa to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the attending physicien the dorugal Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð peq 2 500 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 300 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Spring Home 5 Residence 6 Other (Specify) 1 Yes 2 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Patural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direc 4 | Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) 105 61 05 address of p tho completed cause of death (Item 23a) (Type, Print) No 15 D.O.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 7 2005

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32. Regispar's Signature

		-	For State Registrar		State	of Ma	ryland /	•	rtment tificate		ealth and Death	l Mental	Hygie Reg	2005	E-real management of the second		82
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			Harford Men  5. Social Security Number	6. Sex			(In yrs. last b	birthday)			e de Gr	rs. 8. Date	of Birth		rfor Birtho		te or Foreian
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<b>336</b> ars afte	l', or	by F	1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ⊠Yes If Yes, G Year or I	ive Dates: W	w II	1	☐ Yes 25	<b>∑</b> No	Specify:			Specify:	Wh	ite	
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ary	is mai		19a. Informant's Name/Relation	ship (Ty	rpe, Print)		15	9b. Mailin	g Address (	Street a	and Number or	Rural Route f	lumber, C	ity or Town, St	ite, Zip	Code)	
D, K	m 27 her tr		Terry Campbell	. (sc	on)				Ingles		Avenu	e, Peri	1	le, Mar			21903
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene.	or of		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation			State	ceme	tery, crem	atory or oth	er place			112				
I <b>ftin</b> nit. Pe	ortant injury e.		<ul><li>4 □ Donation 5 □ Other</li><li>21. Sign flure of Funeral Service</li></ul>				Mt. I		Cemet			/9/05	Ha	ivre de Gi	cace,	Mary	/Land
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Division To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medic	ing Phy al Exami	ner: On the	basis of	examination.	lge, death and/or inv	occurred at restigation, in	the tim	e, date and pla pinion, death of	ace, and due to	o the caus	se(s) and mann and place, and	er as st	ated. the caus	60(S)
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4.	Physici /Medic		Decedent's Name (First, Middle, Las     PAUL	CHER	NOFF						2. Date of Month DEC		Day Ye 2005	ar	3. Time of 11:15	
W.	Examin		4a. Facility Name (If not institution, give SHADY GROVE ADVENT	street and number)				ROCK	Location (	Ξ			4c. County of [		OMERY	
€. •	Funeral Director		5. Social Security Number 6. Se 124-16-0736  Usual Residence of Decedent	X 7. Age	7 (In yrs. 1	8 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, SEPT		1927 9.	Birthp: Coun	ace (State of try) NY	r Foreign
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	in with the 23a or 28s	al Director	10e. Street and Number 217 BOOTH STREET #	311			10f. Zip		0878			10g	Citizen of Wha		try?	
036	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Department of Health and Mential Hygiene any injury or other traumatic event, it a Medical Exacilitat inval he inclined and once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates!	lo	İ	Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		ecify Yes or Rican, etc.)	No-	14. Race - A Black, V Specify:	Vhite,		
Maryland 21215-0036	within 72 ho lene. rthan "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation		16a. Dece	kind of wo DO NOT us	rk done di se retired)	<i>uring</i> mos	st of worki	ing	16	b. Kind of Busin		lustry OF ARM	Y
/land 2	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) MAX CHERNOFF		!	110022			18. Mothe	er's Name		dle, Ma	iden Sumame)			
e, Mary	and 2 sho fealth and 1 m 27 is ma her traums		19a. Informant's Name/Relationship (7) MARC E. CHERNOFF/S		John Di	1393	5 BRO	MFIE		OD, C	SERMAN	TOW		2087	74	
Baltimore,	rtment of H		20a. Method of Disposition  **Mill Burial 2   Cremation 3   4   Donation 5   Other (Specify  21. Signature A Funeral Service Ucens	)	Cé	lace of Dispo emetery, crer RBECK	natory or o MEMOR	ther place IAL	PK   1	12/04	) 4/2005	0	LNEY, MA	ARYI		
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of VII	rnysicien: In this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 1  Inpatier 28a. Date of Injur		ER/Outpatien			r: 4 🗆 Nu	ırsing Hor		esidenc	e 6 Other (	Specify	)	
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=	i o the nospitel or Attentwithin 24 hours after deal To the Funeral Director: completely filled in by the		29a. Certifier X Certifying Phy	building, etc	of my know	wledge, deatl	occurred	at the time	e, date an	nd place, a	City or	he caus	se(s) and manne	r as sta	ited.	
:	within 24	Medical	29b. Signature and title of certifier	iner: On the basis of and manner sta	ted.		- 1	License		ith occurr	ed at the tin	_	and place, and  Date signed (M			
9	5		30. Name and address of person who c		eath (Item	23a) (Type,	Print)	0063					DEC. 1	, 20	005	
1900	Sta Registr		DR. MOHET RASTOGI 31. Date filed (Month, Day, Year) DEC 0 6 20	9901 MED  32 Registra				ROC	KVIL	LE, N	4D 20	851				

For Amend Item ##2 PER Maryland Penantment of Health and Mental Hygiene Registra Amend #19a. Per FH PGC 12-6-05 Gertificate of Death Reg. Ño. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Chapman December 2005 2:02 P M Deborah Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Prince George Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security News 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □XF Days Hours Yrs. 11,1947 Director 577-62-1<del>994</del> 58 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits rei', or items 23e or 28e-f show 1 ☐ Yes 2 √No Director Mitchellville Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20721 USA 1605 Pebble Beach Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☒ Divorced "neturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumetic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Mortgage Lending 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Importent: If item 27 Ie marked oth eny injury or other treumettic event 2008. Be Ethel Arlee Chandler Mason Howard Cobb 2 19a. Informant's Name/Relationship *(Type, Print)* Ethel A. Chapman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel A. Cobb / mother 12929 Victoria Heights Dr. Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 12/6/2005 Alexandria, VA. \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPERATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed as the burial-transit SRONCHIA been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2XER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BB6458714 12-3-2005 30. Name and address of person who completed cause of de h (Item 23a) (Type, Print) HANOUER PARKWAY GREENBELT MD 20770 BHAN DAR BALNATH 31. Date filed (Month, Day, Year) 2. Registrar's S ignature State Registrar DEC 0 6 2005

DHMH 17 Rev 1/2001

Jeremy C. Calico Amend item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 8211AKG State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yea **Physician** Colton Caleco Jeremy December 5, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8690 Dubois Road Charles Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1**∑**M 2□F 214-57-2791 5 Yrs. Director January 4,2000 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23s or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Charles Charlotte Hall Director the h 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20622 USA 8690 Dubois Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Child. Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Unknown Cheryl Caleco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a itam 27 i 8690 Dubois Rd. Charlotte Hall, MD 20622 Cheryl Sherman/Mother 20a. Method of Disposition

4 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H important: if its any injury or ot once. Trinity Episcopal 12/14/05 Newport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00945 AREHART-ECHOLS FUNERAL HOME, P.A. Coho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 567, LA PLATA, MD 20646 such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Head and Ch Due to (or as a consequence of) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No 24a. Was an autopsy certificate has t lirector, page 2 s performed? 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6750ther (Specify) at Scene Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1807 Hours 1 Yes 2 No i Director: A d in by the fi investigation vehich 2 Accident 3 Suicide 12(5/05 motor 6 Could not be Location (Street and Number or Rural Route Number, Sity or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funarel Direct completely filled in by 4 Thomicide roc-dwar To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) | DEC 1 9 2005

THEODORE MIKE

32. egistrar's Signature

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

O.C.M.E.

December 6, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item #8 State of Maryla State Registrar WCHD/SH 12/12/05 per FH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 7, **Physician** 2005 1645 TRUMAN LEROY DOYLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WILLIAMSPORT WASHINGTON HOMEWOOD AT WILLIAMSPORT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8 / 1 / 1 9 P(Birthplace (State or Foreign Months | Days | Hours | Min. | APRILL | 1910 | NEBRASKA 6. Sex 12 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. 95 Director 709-07-8922 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 shoy ust be notified at 1 ☐ Yes 2 1 No Completed by Funeral Director HAGERSTOWN WASHINGTON MARYLAND the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 21742 U.S.A. 20009 ROSEBANK WAY itams 23a 2 should be filed within 72 hours after death and Mental Hygiene. Is markad othar than "natural", or itame 29 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other traumatic avent. The Medical Examiner to Btack, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give. Year or Dates: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) PUBLIC SCHOOL TEACHER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) OLLA ANGELINE YORK ROY EARL DOYLE . Pages 1 and 2 should be ment of Health and Mentatent: if itam 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20009 ROSEBANK WAY, HAGERSTOWN, MD LEONTINE T. DOYLE, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ö Department of Important: if any injury or one 4 □ Donation ) 5 □ Other (Specify)

1. Signature (Funeral Specify) BOONSBORO CEMETERY 12/10/2005 BOONSBORO, MARYLAND 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME Part End the disease, or complications the guised the death. Do enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one caus on a chiline. BOONSBORO, MARYLAND 21713 Approximate Interval Between Onseyand Death tmmediate Cause (Final Priysician WK disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. r use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CATICA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death death 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 To tha 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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	<b>b</b>		1 - State Registrar	4)		Cei	titica	te of L	Death	2. Date of	Reg. N	ă. U U U	→ 1 1 0 <i>1</i>
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	s 23a	rai	16613 Tammany Lan				217				U.S		
	item item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1		.S.   13. 1	Was Dece If Yes, spe	dent of Hi ecify Cuba	ispanic Origin n, Mexican, P	? (Specify Yes o Puerto Rican, etc	r No- .)	14. Race - Ame Black, White	
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21215-0036	72 hours after death with the Maryland 'naturel', or items 23s or 28s-1 show disal Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation		16a. Dece	dent's Usu	ial Occupa	ation during most of	f working	16b. I	Kind of Business/	
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Maryland	should and Men is marke	ဥ	19a. Informant's Name/Relationship (7			19b. Mailir	ng Addres	s (Street a				or Town, State, 2	žip Code)
	Health a Health a tem 27 is		Drista Mara Stult	z / Daught	er	403 W	est	wilso	on Blvd	l Hagers	town l	Maryland	21740
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "nature!, or items 23s or 28s-1 show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition  1 Burial 2 Cremation 3	Domough from State	20b. P	lace of Dispo	sition (Na natory or	me of other plac	e)	Date	20c. L	ocation - City or	Town, State
Ĕ	mit. Pag partment cortant: i injury o		4 ☐ Donation 5 ☐ Other (Specify	)	Smi	thsbur	g Cr	emato	ry Dec	9, 20	05 Sm:	ithsburg	, Maryland
Baltimore,	permit. Pages Department of I Important: if ite any injury or of once.		21. Signature of Funeral Service Licent	596								neral Ch own Mary	
187			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each line	the death	h. Do not ent	er the mo	de of dyin	g, such as ca	rdiac or respirato	ory arrest,	3.5	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a Circul	atz	My C	alla	ef Se					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseq	ueoce of):		1	`				
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Profice	cal	HX	nel	2150	an				
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Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗆 Fetal	Ideath 3□		regnancy			1	23d. Date of deli Month	very Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime or di	eath 5L	Other (s	респу)			-		,
Δ.	₽ ₽ ₽		Part II. Other significant conditions or	ontributing to death bu	t not resi	ulting in the u	nderlying	cause give	en in Part I.	23e. i	Did tobacco	use contribute to	the cause of death?
Records,	w requires been sign should be	d ba	Steep aprice	<u> </u>						_   '	I∐Yes 2	!□No 3□Pr	obably 4 Unknown
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n C	ding P. h. After funes	io io	27. Manner of Death  1 ☐ Matural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injun (Month, Day	Year)	28b. Time of Injury	м	28c. Injury Work	rant ⟨? Yes 2.∐No		ibe how inju	iry occurred	
Division	deat deat ctor: , the	fica	3 Suicide 6 Could not be	28e. Place of Inju	rv - At ho	ome, farm, str					on (Street a	nd Number or Ru	ral Route Number,
Ö	i Site	Certification:	4  Homicide determined	building, etc	. (Specify	y)		,,			Town, Stat		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best o liner: On the basis of and manner stat	examina	wledge, death tion and/or in	occurred vestigation	at the time n, in my of	e, date and pointon, death o	place, and due to occurred at the ti	the cause(s me, date an	s) and manner as od place, and due	stated. to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier			(050,701	29	c. License	number		29d. Da	ate signed (Monti	n, Day, Year)
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200	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 9 2	32. Registra	rs Signa	D. A	serie	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2:30 P<sup>M</sup> DECEMBER 4, 2005 GEORGE WILLIAM DICKSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner STEVENSVILLE QUEEN ANNE'S 303 CONGRESSIONAL DRIVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑** M 2□ F 62 149-34-9214 NOV. 21, 1943 NJ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r than "natural", or items 23a or 28a-f shov the Modical Examinational be notified at 1 ☐ Yes 2 No Director QUEEN ANNE'S STEVENSVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21666 USA 303 CONGRESSIONAL DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🗶 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRE-PRESS TECHNICIAN NEWSPAPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd 2 should be fi th and Mental H 27 is marked of r traumatic evan MARIE MILLER ANDREW DICKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 303 CONGRESSIONAL DRIVE, STEVENSVILLE, MD JANINA B. DICKSON/WIFE 21666 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of I tant: If it Department of Important: If it any injury or once. 1 ☐ Burial 2 MCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 12/07/2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Foneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK RD., CHESTER, MD 21619 HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TMS TATEC Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate ba executed Due to (or as a consequence of): 68760 Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) \_ 4☐Pregnant at time of death o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has briegetor, page 2 s autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ₺No 2₩No of Vital Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1- Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after Direct 4 Thomicide ō within 24 hours a
To the Funeral I
completely filled To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 36761

Registrar DHMH 17 Rev 1/2001

State

1 AD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Chall Richm Manyand Primary Care Physician's 2448 Holly Ave St. 10

32. Registrates Signature

Gloren S.

2 243000

2005

31. Date filed (Month, Day, Year)

12/05/

2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:50 AM Gladys Marie Dale NOVEMBEN 27 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner egional Medical Cente WICOMICO eninsula 8. Date of Birth (Month, Day, Year) June 10, 1946 Birthplace (State or Foreign Country)
 DE 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Days Min Yrs. 59 Director 221-28-9104 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or then "naturel", or items 23e or 28a-f shows the modical Examples of the modified at X☐Yes 2☐No DE Sussex Laurel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 425 West 6th St. 19956 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Š 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemarker n/a 9th it of Health and Mental Hyg If item 27 is marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Early B. Conquest Priscilla Kellam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Dale/son 11082 Taylor Mill Rd., Laurel, DE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Department o important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 12/3/2005 Mt. Olive Cemetery Laurel, DE 21. Signature of Fun ral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disense Arten **Physician** 8 weeks orandn /Medical Due to (or as a consequence of Examiner S- uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending phy: d be detached for use as the use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? ena 24a. Was an page 2 s performed' certificate 2. No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30/05 D0041813 person who completed cause of death (Item 23a) (Type, Print) MD 201 ine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 DEC 0 2005 Registrar

		1	For State Registrar	State of Mary			ent of H ate of L			giene Reg. No.	105	41191
	Division	_	1. Decedent's Name (First, Middle, Las	•					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	_		James Davi	d Dive.	lbiss			December	11	2005	1:15 P. M
	Examin		4a. Facility Name (If not institution, give	street and number)		_		Location of Death			County of Death	
			Eden Pines				lagerst nder 1 Year		100 (0)		ashingto	
	Funeral Director		210-07-9000	ox M 2□F	yrs. last birth 88 y	rs. Mor		Hours Min.	8. Date of Birt (Month, Day Jan 1 /	v, Year)	Cou	place (State or Foreign intry) Ina •
	and *	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location						10d. Inside City Limits
	l sho	5	MD. Washing	ton	Hage	ersto	m					1 XYes 2 No
	289-1	ect	10e. Street and Number				. Zip Code	··.		10g. Citize	en of What Cou	ntry?
	with 3e or	Funeral Director	310 Cameo Dr.				21740	)		U. S	S.A.	
	ns 2:	era	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. Was D	ecedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	. 14	4. Race - Ameri	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show amy injury or other treumatic event, the Maylical Examiner must be notified at ance.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 1 ¶	43-45		specify Cuba as 2 No	Specify:	Hican, etc.)		Black, White Specify: Wh	
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<u> </u>	ould Men parke	၉				NA-111- A.I	(211-	and Number or Rui			Town State 7	- Code)
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	St Regist	ate rar	DEC 1 9 2	32. <b>Tegistrar's</b>	, &	Gran				_		

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Maryland	Mental Mental narked o	To B	Wilson B. Deafen			T				a J. Vai				
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice			22	. Name ar	nd Addres	s of Facility	Rausch I	Tuner	al Hom	9	
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DHMH 17 Rev 1/2001

Registrar

2005

TILER J. FUNK 05-08430 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 13, **Physician** Tyler James Funk 5:53P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE UPPERCO-21622 ORWIG ROAD Freeland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 217-17-6717 18 Yrs July 20, 1987 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ahow rthan "natural; or itame 23e or 28e-f ahov the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director Baltimore Freeland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 21622 Orwig Road 21053 U.S.A. death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) Community College College (1-4or 5+) Student permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other traumatic avant, odge. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Cheryl Leslie Denton David Nagle Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David N. Funk/Father 21622 Orwig Rd., Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. 17, Mountville, PA 1 XBurial 2 ☐ Cremation 3 XRemoval from State Mountville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Signature of Funeral Service Licensee 24 Second St., New Freedom, PA 17349 James & 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Shotgun Wound **Physician** Intraoral /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physicien are the burial-t Box 68760. Physician/Medical as ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Yes 2 

No 24a. Was an has page certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 XYes 2 □ No 2 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Faund PM 1 Natural 5 Pending Subject Shot Self

Location (Street and Number or Rural Route Number City or Town, State) 21622 Sympa Pd 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 12/13/05 investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 21622 orwigRd woods 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rol Hallan me DECEMBER 14, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L#ROL 111 PENN STREET BALTIMORE MARYLAND 21201 HALLANIU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

/Medical **Examiner** certificate be executed Records, P.O. Box 68760 Division of Vital

for use as the burial-transit signed by the attending physician be detached ospital or Attending Physician: Thours after death.
uners! Director: After this certificat if filled in by the funeral director, p To the Hospital o within 24 hours aft To the Funeral Di complately filled in

**Physician** /Medical

Examiner

Director

Funeral

Completed

Be

Examiner

Physician/Medical

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Completed

Be

2

Medical

State Registrar 29a Certifier

**Funeral** 

Director

'natural', or Items 23a or 28a-f show

other traumatic event, the Medical Examiner must be notified at

e filed within 72 hours after di al Hygiane. other than "natural", or Item

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If Item 27 is marked other in any injury or other traumatic event, Item

Physician

Saltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death Natural 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

one)	and manner stated
29b. Signature and title of certifier	
) XC	///

29c. License number

29d. Date signed (Month, Day, Year)

Can

D0058410

12/4/05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARG GHULAM 31. Date filed (Month; Day: Year)

6266 32. Registrar's Signature AMROWWOOD LT.

		•	1 - For State RegistraAMEND#8perFH	State of Mar 12/7/05,BM						nd M		jiene leg. No.	005	4119	6
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Charles Paul	Furnari							2. Date of Dea Decembe		2005	3. Time of De 7:55P.	
	Examin		4a. Fecility Name (If not institution, give s Cherry Lane Nursin					Town, or aurel	Location of	Death		Pr		George's	
	Funeral Director		3/9-20-90/0	7. Age (	In yrs. la 7	st birthday) 8 Yrs.	If Unde Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth Month, Day June 22	, 1957	27 9. Bij Wa	thplace (State or Fountry) Shington,	oreign DC
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Ge		oc. City.	Town or Lo	cation							10d. Inside City I	
	with the 3a or 28a st be not	Funeral Director	10e. Street and Number 9258-28 Cherry Lar	ie			10f. Zij	Code 2070	08		1		ed St		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mentall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avant, it is Modical Exact from mat be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:	er in U.S		Was Dece f Yes, spe	7.7	spanic Orig n, Mexican, Specify:	in? (Spe Puerto	cify Yes or No- Rican, etc.)		Race - Am Black, Whi pecify:	erican Indian, te, etc. White	
0-61717	within 72 ho jiene. r than "natur ir e Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			16a. Deced (Give life. L	kind of wo	rk done d se retired)	ation luring most )	of worki	ng		of Business		
	utd be filed dental Hyg irked otha rtic avant,	To Be C	17. Father's Name (First, Middle, Last) Joseph	Fu	ırna	ri			18. Mother		(First, Middle,	Maiden Si		rone	
Š	and 2 should eaith and Men n 27 is marke tar traumatic	•	19a. Informant's Name/Relationship (Ty Eileen T. Furnari								urel, Ma				
D .	Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	emoval from State	Ce		leave	n Cen	netery	12,	/8/2005	Silv	er Sp	ring, Mary	/land
ם	Departit Departit Import any Inj 2002e.		21. Signature of Funeral Service License Donald U. 1	ngwood	4.	44	1UU P	owdei	r Mil.	L Ko	Funera ad Belt	SVIII	ne, PA .e. Ma	ryLand207	705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ms that caused the cause on each line.  Metastat  Due to (or as a common cause)	ic	Lung C			g, such as o	eardiac c	r respiratory arr	rest,		Approximate Interval Between Onset and Dea 2 years	
	certificate be executed ading physician and use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c											
09/90	rtificate be ng physici as the bu	Aedical	IF FEMALE:	J											2 10
0	death e atter id for u	hyslcian/Me	23b. Was decedent pregnant in the past 12 months?  1 \( \times \) Yes \( 2 \) No \( 9 \) Unknown	3c. If yes, outcome of 1□Live birth 2   4□Pregnant at tin 9□ Unknown	Fetal	death 3	Ectopic p Other (s					23	d. Date of de Month	livery Day Yea	ar
cords, P	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions con	tributing to death but	not resu	Iting in the ur	nderlying	ause give	en in Part I.		-	bacco use es 2 🗆		o the cause of deat robably 4 □Unk	
Lec	The larate has	Completed									24a. Was a autops perfor 1 Yes	an sy med? 2 No	death?	utopsy findings ava completion of caus s 2 \( \text{No} \)	ailable se of
ा शाबा	Physician: this certific ral director,	To Be	T res ZA No	lospital:					er: 4 🕱 Nur	sing Ho	ne 5 Resid	ence 6 (		ecify)	
DIVISION	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	27. Manner of Death  1 \( \Delta \) Natural 5 \( \Delta \) Pending 2 \( \Delta \) Accident investigation 3 \( \Delta \) Suicide 6 \( \Delta \) Could not be	28a. Date of Injury (Month, Day )		28b. Time of Injury	М		rat (? Yes 2 □ N	10	28d. Describe h			ural Route Number	,
2	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	I Certif	4 Homicide determined  29a. Certifying Physics	28e. Place of Injury building, etc.					ne date and		City or Tow	n, State)			
	tha Hos hin 24 ho tha Fun npletely	Medical	(Check only 2 Medical Exami	nar: On the basis of eand manner state	xaminati	ion and/or inv	vestigation	n, in my op	oinion, deat	h occurr	ed at the time, d	late and p	lace, and du	e to the cause(s)	
	1D	~	29b. Signature and title of certifier	May		MD		0. License 0.5105						th, Day, Year) 5, 2005	
	·		30. Name and address of person who co Andres Salazar, MI	3621 Ligo	n Ro	oad El	lico		ty, M	lary.	Land 21(	)42			
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar	s Signat	N'S	resti	3							

		•	For State Registrar	State of Ma	arylan		irtment			and M	ental Hy	giene Reg. No. () (	)5	1197	
	Physici		1. Decedent's Name (First, Middle, Las Paul Rene Fiene								2. Date of De Month Decemb	Day	Year 005	3. Time of Death 2311 M	Į
+	/Medic Examin	er	4a. Facility Name (If not institution, give 253 Vista Lane				4b. City,		Location o	of Death		4c. County	of Death		-
*	Funeral Director		213-44-3301	9x 7. Aga	e (In yrs. 59	/ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	4, 1946	9. Birthp Cour New	place (State or Foreign htry) York	7
	ne Maryland 8a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Calvert		10c. Cit	by								0d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	be filed within 72 hours after death with the Maryland that Hygiene.  Ind Hygiene.  Independent than "natural", or items 23e or 28e-f show event, the Medical Examinat must be notified at	Funeral Dire	10e. Street and Number  253 Vista Lane  11. Marital Status  1 □ Nøver Marriød 2 ☒ Marriød	12. Was Decedent   Armed Forces? 1  Yes	Ever in U	.S. 13. V	206 Vas Deced Yes, spec	57	ispanic Ori in, Mexican	gin? (Spe	ocify Yes or No Rican, etc.)	United S	State	ean Indian,	
21215-0036	"natural", or	by	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad	ff Yes, Give Year or Dates: ucation		16a. Deced	☐ Yes 2	I Occupa	Specify: ation during most	of worki	ng	Specify 16b. Kind of Br	Wn.	ite <sub>dustry</sub>	
	illed withir Hygiene. ther than nt, the We	Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5	+)	Senior			cal D	esig	ner	Oceanee		Engineer	
Maryland	be d all	To Be	Ernest Fiene  19a. Informant's Name/Relationship (7)	Type Print)		19h Mailig	a Address	(Street)	Alic	ia W	iencek	er, City or Town,		Cadal	
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic <u>once.</u>		Constance Kordell  20a. Method of Disposition  1 Burial 2 X Cremation 3   4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen	Fiene (W.	20b. P	RMF 229 Place of Disposementery, crem	0 971 Sition (Name and Control of the Control of th	Buckete of their place	cland (	To Ro	d., Murmu 7/2005 ISCN Fu	ngee, Vic 20c. Location Alexand neral in	toria City or To	3747Australi own, Sfate Virginia P.A.	ia
100	Physician		23a. Pari 1. Enter ne disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused one cause on each lin	the death	h. Do not ente		of dyin	g, such as			epublic, M	aryıa	Approximate Interval Between Onset and Death	
8760,	The law requires that the death certificate be executed as the has been signed by the attending physicien and bagge 2 should be detached for use as the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf	b. Due to (or as  c. Due to (or as  d	a conseq a conseq a conseq	juence of):	Av	e	3.4	Dis	ecse				
P.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	ıl death 3 ⊑	Ectopic pre Other (spe					23d. Da Mo	te of delive	ery Day Year	
	w requires that been signed by should be deta	by	Part II. Other significant conditions on	ontributing to death b	ut not res	ulting in the ur	nderlying ca	tuse give	en in Part I.		10	Yes 2□No	3 🗆 Prob	ne cause of death?	_
al Rec	ysician: The law is certificate has t director, page 2 s	Completed								_	1 Yes	propried?	rior to con death?	psy findings available npletion of cause of	
Division of Vital Records,	ding Ph h. After th funeral	atlon: To Be	25. Was case eferred to medical examinar?  1 Yes 2 No  27. Mann f Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Day	rv	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	er: 4□Nu	rsing Hor	Check only one 5 Desi			r)	
Divis	al or Atte s after des si Directo ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injubutding, etc.	ury - At ho c. (Specif	ome, farm, stre	eet, factory	, office		-	28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis of and manner sta	examina	owledge, death	occurred a restigation,	at the tim in my op	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and ma date and place,	inner as si and due to	ated. the cause(s)	
)	To t withi To tl	M	29b. Signature and title of certifier	(II)	1	M	290	License		2V		29d. Date signed	d (Month,	Dey, Year)	
	15		30. Name and address of peson who of Raymon A. Noble,					wn,	Mary]	and	20639	1-1-10			
	Sta Registr		31. Date filed (Month, Day, Year) DEC - 7 2005	32. Registra	ar's Signa										

				State of Ma				d Mental Hy	•	•
			For Stata Registrar		Ce	rtificate of	Death		Reg. No.	5 1.1100
	Physici	an	1. Decedent's Name (First, Middle, Las	_				2. Date of Dea Month	Day Yea	
	/Medic	al			2EELA		-1	12	4 20	
7	Examin	er	4a. Facility Name (If not institution, give		1-0000	PRINTE	16. 34		4c. County of D	eath
	Funeral	ν' — 	5. Social Security Number 6. S		(In yrs. last birthday	If Under 1 Year	If Under 24 F	Hrs. 8. Date of Birt	h 91	Birthplace (State or Foreign
	Director		218-12-9260	2 F	82 Yrs.	Months Days	Hours N	lin. (Month, Da)	23 M	Country) laryland
	p v		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	faryla ed al	or		ort	Too. Only, Town or E	Lusby	7			1 Yes 2 No
	28e-1	Director	Maryland Calv  10e. Street and Number	ert		10f. Zip Code			10g. Citizen of What	
	s within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28e-f ehow the Medical Examinat must be notified at	I D	423 Thunderbi	rd Drive		206	557		USA	
	deatl	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- uerto Rican, etc.)	14. Race - A Black, W	merican Indian,
36	or it	by Fu	1 Never Married 2 Married	1 Types 2 No	1944-	1 ☐ Yes 2 ☑ No	Specify:	,	Specify: B	
Ö	hour:		3 □ Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	1945	edent's Usual Occup	nation		16b. Kind of Busine	
15	within 72 ene. then "nei	plet	(Specify only highest gra	de completed) College (1-4or 5+	(Giv	e kind of work done DO NOT use retired	during most of d)	working	Federa1	Government
212	giene grentha	Completed	9	College (1°401 5+	' C	urator			Navy	
pu	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last) 01iver	Free	land		18. Mother's Lill:	Name (First, Middle,	Maiden Sumame) Plater	
ya	D 2 2 0	70	19a. Informant's Name/Relationship (			ing Address /Cares			or, City or Town, State	
Maryland 21215-0036	12 ha 7 is 7 is		Myrtle William			0 Stinne				MD 20639
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	\	20b. Place of Disp	osition (Name of ematory or other place	rel	Date	20c. Location - City	or Town, State
E	Pages ment of ant: If it		1  Surial 2  Cremation 3  C 4  Donation 5  Other (Specify					/10/2005	Huntin	gtown, MD
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service Licen	isee	. 2	22. Name and Addre	ss of Facility	Sewell F	uneral H	ome red.,MD2067
_	89 2 2 3		Blocks U.	Servell		-				red.,MD2067
r			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not er	nter the mode of dying	ng, such as card	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
1.5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ARI	>S					
	Examiner			Due to (or as a	consequence of):	. Des	11.1011	. ^		
9	<b>≯</b> €3	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of).		MON			1
	sicien and burial-transit	Examiner	that initiated events	· Sala	4430-	ISL OR	STYL	COLONS		
, 0	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a	consequence of):			11-3-1115-2110		
68760	~ ~ ~	dical		d.				_		1
9 X	The law requires that the death certificate tie has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome o	f pregnancy				32d Date of	dolivon
Вох	atten atten i for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	′		23d. Date of a	Day Year
P.O.	at the de by the a	hysl	1 Yes 2 100 9 Unknown	9□ Unknown						
	res that igned be be det	by P	Part II. Other significant conditions o	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.			e to the cause of death?
ord	w require been sig should b	ted	Mogastic ca	nco				_ 1 U Y	′es 2.⊠nNo 3.⊟	Probably 4 Unknown
ecc	has be	Completed	Mo thyputer	Sie				24a. Was autop	sv prior	autopsy findings available to completion of cause of
<u>~</u>		Con						perfor 1 ☐ Yes	rmed? death 2 No 1 □ Y	? es 2♥No
Vital Records,	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Dth	ar	Death (Check only or		
ō.	Phys r this rat di	. To	1 Yes 2 No 27. Manner of Death	28a, Date of Injury	28b. Time	of 28c. Injur	v at		lence 6 Other (S	pecify)
lon	Attending r death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Wor M 1 □	k? Yes 2 □ No		. ,	
Division	if or Attending Patter death. Director: After of in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, s'	treet, factory, office		28f. Location (S City or Tow	Street and Number or	Rural Route Number,
۵	ital or A rs after el Dire led in by	Cert		li)					·	
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	edical	(Check only 2 Medical Exan	ysician: To the best of ninar: On the basis of e	examination and/or i	th occurred at the tir nvestigation, in my o	me, date and pl pinion, death o	ace, and due to the o	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner state	ed.	29c. Licens	e number		29d. Date signed (Mo	onth. Day, Year)
	F 2 5 8		· /loh	Kmi	$\overline{}$	TIC	15 333		12/4/0	5
	_		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	, Print)		2		
k	>+1		Welyhin	Ship	110 Hospi	THE D	12.	Juno	From.	HO 20678
	Sta		31. Date filed (Month, Pay, Year) DEC = 7 2005	32. Registrar	's Signature					
1, 4	Registr	ar	2003	Mayer J. S.	Coaste	<b>F</b>				

			1 - For State Registrar	State of M	larylan	-		nt of H te of L			F	Reg. No.	005	eventuman eventuman mappa	99
· 3	Physici	an	Decedent's Name (First, Middle, La.	st)						2	Date of Dea Month	ath Day	Year	3. Time of 4:25	f Death Ам
1	/Medic	al	Edna Frankowski  4a. Facility Name (If not institution, giv.	etroet and number	1		4h Cih	Town or	Location of		ecember		2005 County of Death		<b></b> ₩
	Examir	ier	Stella Maris Hosp		/			onium		Douth			Baltimo		
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs.	last birthday)		er 1 Year	If Under 2 Hours	24 Hrs. 8 Min.	Date of Birt (Month, Da)		9. Birth	nplace (State ountry)	or Foreign
	Director		Usual Residence of Decedent	□M 2 <b>⊠</b> F	88	Yrs.		Days	Hours		y 24,			ecticut	
	ehow	<u></u>	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	
	28a-f	Director	MD Howard  10e. Street and Number		C	olumbi		ip Code				10a Citi	zen of What Co		-X
	with a or 3		9465 Black Velv	o+ Tano			101. 2	2104	6					oritry:	
	me 23	Funeral	11. Marital Status	12. Was Deceden		.S. 13.	Was Dec			jin? (Specif	y Yes or No-		SA 14. Race - Amer		
21215-0036	4 within 72 hours after death with the Maryland liene. r then "naturel", or iteme 23a or 28s-f ehow the Mudical Expiding of out be notified at	by	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2√√ If Yes, Give Year or Dates:	No		r Yes, sp 1 ☐ Yes		n, мехісап Specify:	, Риепо ни	can, etc.)		Specify:	vhite	
2-0	72 ho	Completed	15. Decedent's E			16a. Dece	kind of w	ork done o	lurina most	of working		16b. Ki	nd of Business/l	ndustry	
2	within iene.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	)						
121			12 17. Father's Name (First, Middle, Last,			Recor	ds C	lerk	18 Mothe	r's Name (I	First, Middle,		rcraft Sumame)		
and	b d la b	o Be	Joseph Gajdek								Biesia				
Maryland	d 2 should it and Menith and Menity is market traumatic	ř	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addres	ss (Street a					r Town, State, 2	ip Code)	
	1 and 2 : Health ar tem 27 is		Ann C. Frankows	ki/ Daugh	ter	9465	Bla	ck Ve	lvet	Ln.	Columb	oia,	MD 210	046	
ore,	S - = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑	Company from State	20b. F	Place of Dispo emetery, crea	sition (Na natory or	ame of other plac	е)	Dat	е	20c. Lo	cation - City or	Town, State	
Ĕ	Pages ment of ant: If its ury or o		4 □Donation 5 □Other (Specif		St.	Charl			ry	12-12-	-2005 F	'arm	ingdale,	NY	
Baltimore,	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service Licer	AA	12								ke's Fan tt City,		I Inc.
零			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the deat line.	h. Do not ent	er the mo	ode of dyin	g, such as	cardiac or r	espiratory ar	rest,		Approximat Interval Bet Onset and	tween
	Physician		Immediate Cause (Final disease or condition	a. CEREBR	OVASC	ULAR A	CCID	ENT						Oriset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):									
,		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseq	wence of):									
ó	te be executed ysician and ie burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):	-	-							
8760,	A 2 9	lical		d			_						-		
x 68	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy.							201 0-1-16		
О. Вох	at the death certifical by the attending phy nached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 Live birth 4 Pregnant	2 Feta	I death 3	Ectopic Other (	pregnancy specify)					23d. Date of deli Month		Year
<u>α</u>	that the by detact		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying	cause givi	en in Part I.		23e. Did to	obacco u	ise contribute to	the cause of o	death?
rds,	w requires been sign should be	ed by							_		101	res 2[	□No 3□Pro	obably 4X	Unknown
Record	has has	Completed										rmed?	death?	ompletion of o	available cause of
Vital		0	25. Was case referred to medical						26. Place	of Death (	1 ☐ Yes Check only o	-	1 ∐ Yes	2□ No	
	S D	O B	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1   Inpat	tient 2	ER/Outpaties	nt 3 🗆 🛭	Oth	ar.				6 NOther (Spec	ify) HOSP	TCE
ion of	ding After fune	ation: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigatio	28a. Date of In (Month, D	jury ay Year)	28b. Time o Injury	f M	28c. Injun Worl	/ at <br Yes 2 □ l		d. Describe h	now injur	y occurred	4001	TOL
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At h		reet, facto	ory, office		28	f. Location (S City or Tox		d Number or Ru )	ral Route Nurr	ıber.
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	edicai 0	29a. Certifier (Check only one) Certifying Pl	nysicien: To the bes niner: On the basis and manner s	of my kno of examina stated.	owledge, deat ation and/or in	h occurre vestigation	d at the tin	ne, date and pinion, deat	d place, and th occurred	d due to the at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				2	9c. License	e number			29d. Dat	te signed (Monti	n, Dey, Year)	
)_				1-			1	DY	3725	_			12/5/0	5	
(2	)aa		30. Name and address of person who	completed cause of	death (Iter	п 23а) (Туре,	Print)						1		
			DR. TARIO MAHMO 31. Date filed (Month, Day, Year)			NEY VA	LEY	RD.	TIMO	NIUM,	MD 21	093			
4	Sta Regist	ate rar		<sup>32. Heg</sup>	ifar's Signa		Con	0							

DHMH 17 Rev 1/2001

4:25 a.m.

DECEMBER 5, 2005

EDNA FRANKOWSKI

DHMH 17 Rev 1/2001

Registrar

DFC 2 1 2005

State Registrar

31. Date filed (Month, Day, Year) 32 Registrar's Signature

29b. Signature and title of certifier

DEC 15 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

29c. License number OCME

29d. Date signed (Month, Day, Year) December 9, 2005

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 20051 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 28, 2005 **Physician** Guevara Ermelinda Jesus 1445 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 XF 42 214-23-3809 Director 7/31/1963 El Salvador Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
ansi: If item 27 is marked other than "natural", or iteme 23e or 28e-f ehow ansi: If item for a should be noted than "natural", or other traumatic event, is mailer for the staumatic event in the profile and the notified at Montgomery 1 Yes 2 No Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12523 Eastbourne Drive 20904 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1½ Yes 2□ No Specify: El Salvador Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeepper Domestic 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacinto Tejada Maria Angela Maldonado ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 permit. Pages 1 and 2 a Department of Health ar Important: if item 27 is any injury or other trau Rene Guevara/Husband 12523 Eastbourne Drive Silver Spring, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/02/05 Gate of Heaven Silver Spring, Md 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Lice PHILIP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 hrs Electromechanical dissociation /Medical Due to (or as a consequence of) Examiner Shock if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Intraoperative Rheeding Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{No} \) Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown cate has been signed page 2 should be det Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? left lung mass 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No 24a. Was an autopsy performed? 1X Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred
Injury aberrant blood 27. Manner of Death 28b. Time of After 1:15 M 1 Natural 5 Pending investigation hours after death. uneral Director: Af 11/28/05 2 X Accident vessel 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

HOLY Cross Hospital

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 00 Forest Glen Rd
20 9 10

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Suicide filled in by 4 | Homicide 24 hours a 29a. Certifier Medical within 24 ho To the Func (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20562 Nov.30,2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) MS. 10215 Fernwood Rd. Bethesda, Md 20815 Barry J.Levin 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 13, 2005 5:45 A JOSEPH F. Dec. HOLOCHWOST /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CENTER SALISBURY, PD . 2.25

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. (Month, Day, Mar. 5, BALISBURY REHAB & NURSING CENTER MICOWICO 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1∰M 2□F 061-12-6667 1918 New York Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Wicomico Salisbury Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31049 Mt. Hermon Road 21804 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 □ No World If Yes, Give Year or Dates: War T 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 XWidowed 4 Divorced War II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Grumman's Aviation **Employee** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Holochwost Josephine Mable Jacobson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Thomas Holochwost (Son) 27131 Cash Corner Road - Crisfield, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State d. Fay... artment of H ortant: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 12/18/05 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD Robert H. Bradshaw, 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 00 /Medical Due to (or as a consequence of): Examiner 40ac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live binh 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown certificete has been signed t rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 res 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DNG 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 AMatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🖸 😂 🖬 Tying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier news 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State Registrar WILLIAM ROBINS, M.D.

31. Date filed (Month, Day, Year)

200 CIVIC AVE., SALISBURY, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Harris Charles 13:30 P DECEMBER 2005 16, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MEMORIAL HOSPITAL ALLEGANY CUMBERLAND 8. Date of Birth Apr 11, 1933 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**√** M 2□ F MD try) 72 218-24-8061 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 showning or other traumatic event, the Medical Experiments 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland MD 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21502 USA 505 Valentine Avenue by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1. Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Year or Dates: Korea 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Gas Station owner-operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche M. Rowe Harris Bernard A. Harris ပ 19b. Mailing Address *(Street and Number or Rural Route Number, Cit*y or Town, State, Zip Code) 505 Valentine Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) wife Donna Harris 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 12/19/2005 Cumberland MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. NamScarpelli Puneral Home, P.A 108 Virginia Avenue, Cumberland, MD 21502 23a. Part In the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sprior, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) where on longterm Ventilator Physician /Medical metabolic encephlipaty **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examiner The law requires that the death certificate be executed burial-transit ed by the attending physicien and detached for use as the burial-trar by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 X No 1 Tyes or Attending Physician: director, Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Inpatient 4 ☐ Nursing Home 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29c. License number

D0062429

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760, completely filled in by the funeral within 24 hours a To the Funeral I To the Hospital

> Virginia Avenue Cumberland MD 21502 Ageel Saleem 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

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			For Stete Registrar	State of Ma	-	epartmer Certificat			and M		gieņe Reg. No. ()	05	41206
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Lorraine A.	Haas		4h Cina	Tau-	Landin		2. Date of Dea Month	Day O1	Year OS unty of Death	3. Time of Death
	Examin	er	4a. Fecility Name (If not institution, give 312 Buttonw	oods Rd.		E	1ktc	Location on the control of Under a control of Under a control of the control of t		2.5	Ced	ci1	
B	Funeral Director		120-36-9558	ax	e (In yrs. last birth 58 Y	Months		Hours	Min.	B. Date of Birtl (Month, Pay April	1,19	4 7 Sinn	place (State or Foreign nto) NY
	faryland stand	or	Usual Residence of Decedent           10a. State         10b. County           MD         Cecil		10c. City, Town							1	10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28e-f	Director	10e. Street and Number		EIK		Code				•	of What Coul	ntry?
036	be filed within 72 hours after death with the Maryland Hygiene.  d other then "neturel", or items 23e or 28e-f show event, tre Medical Examiner must be notified at	by Funeral	312 Buttonw  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		spanic Ori n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		• A •  Race - Americ  Black, White,  ecify: Wh	etc.
21215-0036	filed within 72 ho Hygiene. ther then "netur int, tre Medicell	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2		5+)	Decedent's Usu 'Give kind of w life. DO NOT u	ork done d ise retired	during mosi )		ng		of Business/In	dustry
Maryland 2	should be filed and Mental Hygi e marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Howard Ross					18. Mothe	r's Name	(First, Middle, en McC			
	1 and 2 Health a tem 27 li		19a. Informant's Name/Relationship ( Jennifer Haas/ 20a. Method of Disposition	daughter	20b. Place of I	95 Cor	sica	a Ave	ۥ,	Bear, ate mber	DE	wn, State, Zip 19701 on - City or To	
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Service Licer	/)	A11 Sa	aints 22. Name a	Ceme	etery	6,	2005 neral		ingto	n, DE
	Pnysician /Medical Examiner	Examiner	23a. Part 1. Emer the disease, or som shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as b.	a consequence of	n):	de of dyin	g, such as	cardiac o	E1kter respiratory ar	on, M	D 21	Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 75 No 9 Unknown	d. 23c. If yes, outcome	2 Fetal death	3 □Ectopic p 5 □ Other (s					23d.	Date of delive	ery Day Year
<u>α</u>	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlying	cause giv	en in Part I.		23e. Did to	_		he cause of death?
l Records,	The law requir ate has been si page 2 should	Completed								24a. Was autop perfor 1 ☐ Yes		4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
Vital	ding Physicien: The h. After this certificate h. funeral director, page	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patient 3 D	OA Cth	00		(Check only one 5 esid		Other (Specif	fy)
Division of	Attending Phirder death. sctor; After this by the funeral	Certification; T	27. Manner   eath  1		iry 28b. Ti <i>y Year)</i> In	ime of jury M	28c. Injun Wor 1 🗌	yat k? Yes 2□	No	8d. Describe h			
Divis	vitel or Attencurs after deathurs after deathurel Director;		4 Homicide determined	building, et	ury - At home, fan c. <i>(Specify)</i>					City or Tow	n, State)		al Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical		ysician: To the best niner: On the basis o and manner st	f examination and	Vor investigatio		pinion, dea		ed at the time, o	date and pla		o the cause(s)
	To Vit		Cland		~ N	10	DO	005	64	49	/2/	15/	25
	10		30. Name and address of person who who was a summer of the company	an MD	death (Item 23a) (1 III West	High S	4.5	rite	302	Elt	(101	n M	D 2192
	Sta Regist		DEC 0 6 2005	Blaves 1	the source	W							

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			- State Registrar			Ce	rtificate	of D	eath			Reg. No	. 000	41201	
	Physicia		1. Decedent's Name (First, Middle, Las	(1)						:	2. Date of Dea Month 1	ath Da	ya Yea	3. Time of Death	
	/Medic		Bryan L	. HUM	-DN,	rey					\ 2	- 6	× 05	10:12 PM	
	Examin	er	4a. Facility Name (If hot institution, give		1 \	. '	4b. City, To	own, or L	ocation o		MAN	4c.	County of De		
***	,			2 >t the		e	Səl	V 231	If Under 2	7	MD	<u> </u>		DMICO	_
	Funeral Director		210 10 3010	M 2□F	6 ( <i>in yr</i> s. <i>ia</i>	3 Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da Sept • 2	7,19	942 Ma	irthplace (State or Foreign Country) Lyland	)
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside City Limits	
	Maryla	tor	Maryland Worcest	er		an Pir								1 ☐ Yes 2 📉 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural; or items 23a or 28a-f show any injury as other traumatic avant, the Madical Examir at most ken notified at once.	Funeral Director	10e. Street and Number / Spruce Court				10f. Zip C	218:	11				izen of What ted St		
	ms 2	nera	11. Marital Status	12. Was Decedent	Ever in U.S	5. 13.	Was Decede	nt of His	panic Orig	gin? (Spec	cify Yes or No Rican, etc.)	-		nencan Indian,	
စ္	s affer	by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1X Yes 2 1  If Yes, Giv 9  Year or Dates:	50 <b>-</b> 19	63	1 ☐ Yes 2		Specify:	, Puerto F	ilcan, etc.)		Black, WI Specify:	White	
9500-61717	hour turn	ed t	15. Decedent's Ed			16a Dece	dent's Usual	Occupat	ion			16b. K	ind of Busines		
Ċ	in 72	Completed	(Specify only highest gra	de completed)		(Give	kind of work DO NOT use	done du retired)	iring most	of workin	g			, a maddify	
<u> </u>	than iene.	E	Elementary/Secondary (0-12)	College (1-4or 5	o+)	Manag	ger					Ver	izon P	hone	
0	other ant,	BeC	17. Father's Name (First, Middle, Last)								(First, Middle,				
yland	ould be Menfal mrked atic av	To B	Jesse L. Humphr								. Tutw				
Mar	nd 2 sh iith and 27 is m r treum		19a. Informant's Name/Relationship ( Kathryn A. Humphr									-	and 21		
ā,	t Hea Heam item		20a. Method of Disposition		20b. PI	ace of Disp	osition (Name matory or oth	e of	)	Da	ate	20c. L	ocation - City	or Town, State	_
Ê	Criston Page		P Burial 2 ☐ Cremation 3 ☐     Donation 5 ☐ Other (Specify)		MD	Vetera	ans Cer	nete	ry 12	2/8/2	005	Crow	msvill	e,Maryland	
Baitimore,	parfir ports y inju		21. Signature of Funeral Service Licer	509	1.4	$D_{\ell}^{2}$	2. Name and	Address	of Facility	rdt	Finera	1 Hc	me DA		_
n	88 5 8		Monald V. F.	so gevi	vely	- 44	400 Pov	wder	Mill	Roa	d Belt	svil	le, Ma	ryland 20705	5_
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each li	the death	. Do not en	ter the mode	of dying,	, such as	cardiac or	respiratory ai	rest,	Ĺ	Approximate Interval Between	
Ŋ	Physician		Immediate Cause (Final disease or condition	. METAS	TAT	ic s	AUAN	104	CR	4	CAR	CIN	DMA	Onset and Death	TH
	/Medical		resulting in death)	Due to (or as				T M S							
	Examiner	_	Sequentially list conditions,	b. Due to /er ee	2 2000000	(anaa af):									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience oi):									
	xecut and al-trar	xan	that initiated events resulting in death) Last	cDue to (or as	a consequ	ience of):								+	
200	te be executed ysicien and ne burial-transit	calE		d											
200	ificate g phys														
XOX	anding use	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy	∃Ectopic pre						23d. Date of c	delivery	
n n	res that the death certificati igned by the attending phy be detached for use as the	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at			Other (spe						Month	Day Year	
л О	hat fhed by for the detach	Phy	Part II. Other significant conditions of		ut not resu	ulting in the	inderlying car	use diver	n in Part I		23e. Did to	obacco	use contribute	to the cause of death?	-
Hecords,	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	d by	Turin one organization				andonying out							Probably 4 Dunknown	
Ö	aw require s been sig 2 should b	ojete									24a. Was		24b. Were	autopsy findings available	_
Ĕ	sician: The law certificate has b rector, page 2 s	Completed										rmed? 2 X No	death		
Vital	Physician: r this certifica aral director, p	Be C	25. Was case referred to medical examiner?								(Check only o	ne)			
<u>-</u>	hysic als ce I dire	To [	1 Yes 2 No	Hospital: 1   Inpatie	ent 2 🗆	ER/Outpatie	nt 3 DOA	Other	4 □ Nu	rsing Hor	ne 5□ Resid	dence	6 Other (S	pecity tospica	
_ _	ong P	on:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time ( Injury		C. Injury	?		8d. Describe I	now inju	ry occurred		
SIO	tendi leath. tor: A fhe fu	cati	Accident investigation  3 Suicide 6 Could not b				М		es 2 🗆 i		0( )				
Division of	i or At affer o Direct	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury · At no c. (Specify	me, farm, s	reet, factory,	office		2	City or Tox	vn, State	na Number or 9)	Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier Certifying Ph	ysician: To the best niner: On the basis o and manner st	f examinat	wledge, dea ion and/or i	th occurred a rvestigation, i	it the time in my opi	a, date and inion, deal	d place, a th occurre	nd due to the d at the time,	cause(s date and	) and manner d place, and d	as stated. ue to the cause(s)	_
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier				29c.	License	number			29d. Da	te signed (Mo	nth, Day, Year)	_
}	12		1-5-Car	- eri	1	21	1	200	520	110		/	2/41	105	
	1		30. Name and address of person who	completed cause of c	death (Item	23a) (Type	, Print)	200 1			Chris	10 41	RIC	105 105 MD: 218=1	
表	Sta		31. Date filed (Month, Day, Year)	32/ Registr	ar's Signa	ture	and s	000		/	JH 613	100	7	mo or	_
	Registr	0.0	DEC 0 7 20	115 /40	- LB	1	MAN AND AND AND AND AND AND AND AND AND A								

DHMH 17 Rev 1/2001

			T = For State Registrar	State of Marylan		artment of F rtificate of		F	leg. Nd.2. ()	05	41208
ı	Physicia		Decedent's Name (First, Middle, Last Irene	st)	Hay	yes .		2. Date of Dea Month Decembe		05°	3. Time of Death 1:45P. M
	/Medic Examin		4a. Facility Name (If not institution, give Laurel Regional			4b. City, Town, o Laure	_	eath /	4c. County	of Death	eorge's
	uneral irector		133-30-3010	**	last birthday) 9 Yrs.	If Under 1 Year Months Days	Hours M	8. Date of Birth in. (Month Day OC L 22	1 <b>9</b> 26	9. Birthp Geriii	elace (State or Foreign
e Maryland	Sa-f ehow diffied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		y, Town or Lo Laurel					1	0d. Inside City Limits
h with th	23a or 20 at be no	al Dire	9010 Briarcroft L	ane, #102		10f. Zip Code	20708		German		try?
d 21215-0U36 filed within 72 hours after death with the Maryland Hydiene.	then "netural", or Items 23a or 28a-f ehow in Medical Exarch ar must be ricitlied at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		e - Americ ck, White, /: Wh	
d 21215-0036 filed within 72 hours af Hydiene.	r then "netu I's Medicul	ompletec	15. Decedent's Ed (Specify only highest grades)	ducation de completed) College (1-4ar 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired CY Aide	eation during most of d)	working	16b. Kind of Br		,
<b>–</b> • –	~ S	To Be C	17. rathers Name (Pirst, Middle, Last)  1					Maiden Surnan	(unk)	,	
, Mary and 2 sho	n 27 is ma er trauma		19a. Informant's Name/Relationship (Harold P. Koerner		19b. Mailir 1344	ng Address <i>(Street</i> Bluegras	and Number or S Way G	ambrills,	r, City or Town, Maryla	State, Zip nd 21	.054
Baltimore, permit. Pages 1 ar Department of Hea	Importent: If item 27 Is marked any injury or other traumatic engage.		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disponentery, creed to the control of the	osition (Name of matory or other place Ltan Crem	atory 1	Date 2/6/2005	Alexan		own, State Virginia
Balt permit.	lmport any inj once.		21. Signature of Funeral Service Licer	gward	Dc 44	2. Name and Addre Ona Id V. 400 Powde	ss of Facility Borgwar r Mill	dt Funera Road Belt	l Home, sville,	PA Mary	land 20705
Phy	sician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	ocations that caused the deet one cause on each line. Respirato	h. Do not ent	er the mode of dyir	ng, such as card	liac or respiratory are	est,		Approximate Interval Between Onset and Death 2WEEKS
	Medical xaminer transit the private transit tr		d. Small bowel obstruction								Zweeks
petr		Examiner									
8760, ate be exec		dicai Exa									
Records, P.O. Box 68760, The law requires that the death certificate be executed	by the attending p tached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/			te of delive	ory Day Year
rds, P	gned be de		Part II. Other significant conditions of Chronic obstructi			nderlying cause giv	en in Part I.	23e. Did to			ne cause of death? ably 4 Unknown
		Completed by						24a. Was a autop: perior 1 🗆 Yes	med?	prior to con death?	psy findings available inpletion of cause of
Vita	s certifi lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 12 Inpatient 2	ER/Outpatier	at 3 DOA Oth	0.00	Death <i>(Check only or</i> g Home 5 ☐ Resid		er /Snecifi	······································
VISION Of VITA Attending Physician:	tor: After this certificate has the funeral director, page 2	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	the same of the same of	28d. Describe h			,
DIVISIO	al Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, sti y)	reet, factory, office		28f. Location (S City or Town		er or Rura	Route Number,
Dir To the Hospitel or within 24 hours after	To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the tir vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time, d	ause(s) and ma ate and place,	inner as st and due to	ated. the cause(s)
To the H	Toth	Me	29b. Signature and title of certifier	regual		29c. Licens	3671	2	9d. Date signe Decembe	•	
	1		30. Name and address of person who			Drive, #	102 Lau	rel, Mary	land 20	707	
N 1 3	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7 20	32. Registrar's Signa	ature	40					

			1 - For State Registrar	e of Maryland	-	rtment of He tificate of D		-	giene 005	41209
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Derlea	Louisa He	eath			Month Delember	Day Year	0754 AM
}	Examin		4a. Fecility Name (If not institution, give street and	d number)	- ,	4b. City, Town, or	Location of Dea		4c. County of Dea	th
			Union Hospital	of Ceril 1	any	Elkto	M		Cecil	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	tf Under 24 Hrs Hours Min		h 9. Birn	thplace (State or Foreign ountry)
	Director		234-42-8699	76	Yrs.			SEPT 26,	1929 Wes	t Virginia
•	and	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Loc	ation				10d. Inside City Limits
	Aarylan f show	ō	Maryland Cecil	E1	kton					1 ☐ Yes 2 👿 No
	with the Maryland le or 28e-f show	Director	Maryland Cecil  10e. Street and Number	<u> </u>	.K LOII	10f. Zip Code	-		10g. Citizen of What Co	ountry?
	23e or	۵	368 Frenchtown Road			21921			United St	
	ter death v	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S.	13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (	Specify Yes or No-		erican Indian,
9	or Ite	Ē		d Forces? 'es 2 17 No s, Give	1			rto Rican, etc.)		e, etc.
21215-0036		i by	3 X Widowed 4 □ Divorced Year	or Dates:	1	☐ Yes 2∭X No	Specify:		Specify: Wi	nite
5-0	72 hours "naturel",	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	16a. Decede	ent's Usual Occupa tind of work done do O NOT use retired)	tion uring most of wo	orking	16b. Kind of Business	,
2	s within jiene. r than "	Id II		ge (1-4or 5+)					Supplies	nd Fishing
7			12 17. Father's Name (First, Middle, Last)		Owr	er/Opera		mo /First Middle	Maiden Sumame)	
and	Q 22 Q •	Be	Edward Walker					Worley	Waloen Sumame)	
Maryland	2 should be and Mental Is marked raumatic ev	ဍ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailine	Address (Street a			r, City or Town, State, 2	Zin Code)
Ma	5 = 2 E		Penny J. Mulhern/Daug						Delaware 19	
re,	s 1 a f Hea item othe		20a. Method of Disposition	20b. Plac	ce of Dispos	ition (Name of	1	Date	20c. Location - City or	
e E	m O L		1 N Burial 2 □ Cremation 3 □ Removal f  `4 □ Donation 5 □ Other (Specify)	rom State Gilp	oin Ma orial	atory or other place NOT  Dowle	″ ; ມec	ember 2005	Elkton, Ma	ryland
Baltimore,	permit. Page Department of Important: if any injury or once		21. Signatule of Funeral Service Licensee	_ nemo		Name and Address Cks Home				rryrand
m			Daniel S. D	ules	10	3 W. Stoc	kton St	reet, El	.A. kton, Maryl	land 21921
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. on each line.	Do not ente	r the mode of dying	, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
		2 17	tmmediate Cause (Final disease or condition	to Annu	elia de	d bours	cohasie	shock		Onset and Death
			resulting in death)	e to (or as a consequer	nce of):	1	0	7004		3 101
	LAdillilei		Sequentially list conditions, b.	uptured	Alado	minal	Horto			< 4 hrs
1	ed isit	line	Sequentially list conditions, if any, learning to infine data cause. Enter Underlying Cause (Disease or injury	e to (or as a consequer	nce of):					
V	be executed ician and burial-transit	Examiner	that initiated events c.	e to (or as a consequer	nce of):					
8760	ate be ex nysician he burial	cai E	4 ==							
687	tificate ig phys as the	edic	d.							
Вох	aath certifica attending ph for use as t	M/u		, outcome of pregnanc					23d. Date of del	ivery
	death	icia	In the past 12 months?	ive birth 2 ☐ Fetal de regnant at time of deat Inknown		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
P.O.	requires that the death certificate een signed by the attending phys rould be detached for use as the	hys	9 Unknown							
	es the	5	Part II. Other significant conditions contributing	. 1 1 1	r		n in Part I.		bacco use contribute to	
ord	w require been sig should b	ted	Sinus bradycardia	with I	mypo	racion		1 U Y	es 2 No 3 Pr	obably 4 MUNKnown
ec	aw as b	Completed						24a. Was autop	sy prior to	topsy findings available completion of cause of
<u>=</u>	Th ate pag	Cor						perfor 1 ☐ Yes		2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:			Othor		ath (Check only o		
of	d is	10	1 192 5 140		R/Outpatient 8b. Time of				ence 6 Other (Specow injury occurred	cify)
Division of Vital Records,	une une	tion	1 Natural 5 ☐ Pending	Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	es 2 ☐ No	200. Describe in	ow injury occurred	
isi	i at ii	fical	3 Suicide 6 Could not be	lace of Injury - At home	e farm stre		63 20110	28f. Location (S	treet and Number or Ru	ural Boute Number
Div	ne Hospital or Attendi n 24 hours after death ne Funeral Director: A pletely filled in by the fi	Certification:	4 Homicide determined	uitding, etc. (Specify)	0,12,111,0110	- ,		City or Tow		
	spits hours nera y fille	a	29a. Certifier 1 Certifying Physicien: To	o the best of my knowle	edge, death	occurred at the time	e, date and plac	e, and due to the d	ause(s) and manner as	stated.
	n 24 he Fu	edical	(Check only 2 Medical Examiner: On ti	he basis of examination manner stated.	n and/or inve	estigation, in my opi	inion, death occ	urred at the time, o	fate and place, and due	to the cause(s)
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Σ	29b. Signature and title of certifier			29c. License		I.	29d. Date signed (Monti	h, Day, Year)
	À		Dell W.	In			3309	7	December 1	4,2005
	Q		30. Name and address of person who completed				11	011	11	1
				19 SCM MB		ion Hospi	tell (	Elle ton	MD , 3	1921
	Sta Registi			Manager Signatur	Los	Les son				
		¥	DEC 1 9 2005	Resident for			<del></del>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELSIE POWELL HOTTLE DEC. 8, 2005 9:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOMEWOOD AT WILLIAMSPORT WILLIAMSPORT WASHINGTON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year 11/7/1904 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M XXF 234-01-6471 101 WESTÜÜRGINIA Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other traumatic event, I'm Medical Examiner must be notified at WASHINGTON WILLIAMSPORT 1 Yes 2/0/No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 VIRGINIA AVENUE 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE Completed by If Yes, Give Year or Dates: 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JUGERTHA SHANHOLTZ FRANCES FILES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 122 N. TENNESSEE AVE., MARTINSBURG, WV 25401 PATTI NICHOLAS/NIECE 20a. Method of Disposition

1A Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State DECEMBER ROSEDALE CEMETERY 12, 2005 MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) BROWN FUNERAL FROME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or se a consequance of) ner sician and burial-transit Exami Due to (or as a consequence of): the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 Other (specify) detached 9 Unknown ate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1 Yes Il or Attanding Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 4 Valursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pendina 1 ☐ Yes 2 □ No investigation Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funaral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of con

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month Lay, Year)

DEC 1 9 2005

completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** Howard DECEMBER 14 2005 0540 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jul 30, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral X**□M 2□F 215-36-9148 Director Usual Residence of Decedent perril. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar mans 1 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Y⊟Yes 2 No Cumberland MD Allegany Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 14506 Uhl Highway SE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No MYes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married Ž☐ Married 1 Tes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CSX Railroad lumber & tie Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Saunders Howard Raymond E. Howard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cumberland MD 21502 14506 Uhl Highway SE wife Nancy Howard 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/17/2005 Cumberland Scarpelli Funeral Home, PA MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes Pnysician ardiac acr /Medical Due to (gr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed throse Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 [] Ectopic pregnancy Month Day Year ō in the past 12 months? 5 Other (specify) ☐Yes 2☐No the page 2 should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1□Yes 2☑No 2 ER/Outpatient 3 □ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manny of Death Certification: After Injury 1 V latural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DECEMBER 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Memorial Avenue Cumber MD 31. Date filed (Month, Day, Year) 32. gistrar's Signature State DEC 1 9 2005 Registrar

			State of		artment of Health and M	lental Hygier	ne	
			Registrar	Ce	rtificate of Death	Reg. f		_
	Physicia		. Decedent's Name (First, Middle, Last)				Day Year M	
	/Medic		Everard William H a. Facility Name (If not institution, give street and numb		4b. City, Town, or Location of Death	Dec. 5,	2005 9:04 a *** 4c. County of Death	-
	Examin	er		,				
	Funeral			Age (In yrs. last birthday)	Huntingtown If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Calvert  9. Birthplace (State or Foreign Country)	
	Director		215-26-3565 <sup>1</sup> X <sup>M 2□F</sup>	76 Yrs.	Months Days Flours Min.	8/25/19	29 MD	_
	D ≱ s	-	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Le	ocation		10d. Inside City Limits	-
	Aarylé f sho	.					11∕2 Yes 2 □ No	
	the N	Director	MD Calvert		Huntingtown 10f. Zip Code	10g. (	Citizen of What Country?	$\neg$
	3a or		86 Sheckells Road		20639		USA	
	death	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.	-
9	after or its	Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2	t⊽ No	1 ☐ Yes 21 No Specify:	110411, 010.)	C	
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lan	2 should be fi and Mental F is marked of raumatic evar	1 3	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Rura	al Route Number, Cit	ty or Town, State, Zip Code)	9
Baltimore, Maryland	l and lealth im 27 her t		Melissa Harley/Daught	er 90 S	Sheckells Road,		town, MD 20639  Location - City or Town, State	
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			23a. Part1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on ea	used the death. Do not en	ter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between	
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	/Medical		resulting in death)	as a consequence of):	source I lecent	10100		-
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	ed sit	nine	Sequentially list conditions, I any, leading to minimulate cause. Enter Underlying Cause (Disease or injury	ras a nonsequence of)-				
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9	tificat ng phy as th	fedi						-
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Vital	sicien: Th certificate irector, pag	O	25. Was case referred to medical		26. Place of Deatl	(Check only one)	10 103 2010	
f V	S S	To B	examiner?  1 Tes 2 No Hospital: 1 In	patient 2 ER/Outpatie	nt 3□ DOA Other: 4□ Nursing Ho	me 5 Residence	6 □Other (Specify)	
n of	ng Ph ifter th		27. Mann of Death 28a. Date of Month (Month)	Injury 28b. Time of Injury	Work?	28d. Describe how in	njury occurred	1
sio	Attending r death. actor: Afte	catl	2 Accident investigation 3 Suicide 6 Could not be	At house of any of	M 1 Yes 2 No	29f Location /Street	and Number or Rural Route Number,	-
Division	or A after Dirac	Certification;	determined 200.1 lace to	of Injury - At home, farm, sig, etc. (Specify)	reet, ractory, onice	City or Town, St		
	To tha Hospital or Attending I within 24 hours after death.  To the Funaral Diractor: After completely filled in by the funer		29a. Certifier 1☐ Certifying Physician: To the I	pest of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as stated.	-
	ha Ho n 24 } he Fu pletely	Medical	(Check only 2 Medical Examiner: On the bar and manner)	sis of examination and/or in er stated.	nvestigation, in my opinion, death occurr			
	To tha within 2. To the I complet	Σ	29b Signature and title of certifier	010	29c. License number	29d. I	Date signed (Month, Day, Year)	
)			Toy- UV be		D17324	12	16105	7
	4		30. Name and address of person who completed cause	of death (Item 23a) (Type	Print)	11.01	Storm MD 2063	7
	Sta	te	31. Date filed (Month Day, Year) 32. Re	gistrar's Signature	L CON 12 11	MAINS	LIGION MD	-
	Registi	_	DEC - 7 2005 Serent	gistrar's Signature				

			For State Registrar	State of I	Maryland	_	artment o			lental Hyg	200	-	1 1010
			Registrar  1. Decedent's Name (First, Middle,	( ast)			illicate (	Deali		2. Date of Dea	Reg. No.	)	3. Time of Death
	Physici /Medic		Joe Talma		e					Month		Year 005	8:40 A M
	Examin		4a. Facility Name (If not institution,	give street and numbe	er)		4b. City, Tow	n, or Location	of Death		4c. County of	f Death	
			Heritage Harbou				Annap						del County
ш	Funeral			1X M 2□ E	Age (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
	Director		575-36-5507 Usual Residence of Decedent		36					Feb. 16	3, 1919	Texa	as
	rylanc how		10a. State 10b. County		10c. City, 1	Town or Lo	ocation			-		1	Od. Inside City Limits
	e Ma	Director	MD Calver	·t Co.	Ow	ings							1 □ Yes 2X No
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	eath y	Funeral	1706 Nob Hill C	12. Was Decede	nt Ever in U.S.	13.	2073		rigin? (Spe	ecify Yes or No-	U.S.A		an Indian.
(0	r Item	Fun	1 Never Married 2 Marrie	Armed Force	s?	1				ecify Yes or No- Rican, etc.)		, White,	etc.
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Iteal Exama no must be calified at	l by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date	s:		1 □ Yes 2 🔯	No Specify	<i>'</i> :		Specify:	Wh:	ite
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Mulical Examination in the Landling at	Completed	15. Decedent' (Specify only highes)			(Give	dent's Usual Oc kind of work do	ne during mo:	st of worki	ng	16b. Kind of Bus	iness/Ind	dustry
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d 2	filed y Hygie other 1		17. Father's Name (First, Middle, L			V.P.	OT DAILK				Maiden Sumame	2	
an	Mental Mental arked o	To Be	Dewitt T. Hard	lee				Mi	nnie	Joe Lan	caster		
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evonce.	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Str	eet and Numb	er or Rura	i Route Numbe	r, City or Town, S	tate, Zip	Code)
Σ,	and 2 ealth m 27 i	7	Michael Hardee	(Son)	001 51						Marylano		
Baltimore,	ges 1 it of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 XRemoval from Sta		e of Dispo letery, cre	osition (Name or matory or other	place)		ber 8,	20c. Location - (	ity or To	wn, State
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			23a. Part1. Enter the disease, or									igs,	MD 20736 Approximate Interval Between
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9	ntifica ng ph	Medi	IF FEMALE:										
Вох	death certific e attending p id for use as i	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3[	Ectopic pregna				23d. Date Mon		ry Day Year
0.	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐Unknow	t at time of deat	th 5L	Other (specify	)					
<u>α</u>	requires that the deen signed by the		Part II. Other significant condition	s contributing to deat	put not resulti	ng in the u	nderlying cause	given in Part	I.	23e. Did to	bacco use contri	oute to th	e cause of death?
Vital Records,	quires n sign uld be	ed by	failure	10 1	torius	2				1 □ Y	es 2□No 3	Prob	abiy 4 Mknown
006	e law requir has been si je 2 should	Completed	Delueti	(a		^				24a. Was a	an 24b. W	ere autop	osy findings available inpletion of cause of
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of	N S	2	1 Yes 2 No	Hospital: 1 Inp		VOutpatie	nt 3L DOA	X_			ence 6 Othe		)
uo	ding h. After fune	tion	1 Natural 5 ☐ Pending		Day Year)	8b. Time o Injury	1	njury at ∕ \ Work? 1 □ Yes 2 □		zod. Describe il	ow injury occurre		
Division	Atten deal ctor: y the	ertification:	3 Suicide 6 Could n	ot be 28e. Place of	Injury - At home	e, farm, st	reet, factory, off				treet and Numbe	or Rura	l Route Number,
Ö	s after s after at Direct	Certi	4  Homicide	building,	etc. (Specify)					City or Tow	n, State)		
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in b	edical (	29a. Certifier Certifying (Check only Medicel E	Physicien: To the be xaminer: On the basi	st of my knowle	edge, deat	h occurred at th	e time, date a	nd place, a	and due to the c	ause(s) and man	ner as st	ated.
	To the h within 24 To the F complete	Medi	one)	and manner				ense number			29d. Date signed		
	To To		29b. Signature and title of certifier	7			230. LIC	I no	20		Late signed	TO C	- (Gai)
,			30. Name and address of person v	the completed cause	of death (Item 3	3a) (Tuno	Print)	01.10	28		12.0	0	)
	15+1		Aditua Cha	oca in	0. 60	() KS	idae	Lu Ai	# # T	231 Any	napoli	5.n	10415.CM
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	strans Signatur	Θ		j.					
	Registi	ar	DEC	- 6 2005 <b>▶</b>	Bloque.	J.	Book	0					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 2200 ahnsas William 024 Zoer /Medical 4c. County of Death 4b. Çity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 10 ashin Comi Hospita If Under Wear If Under 24 Hrs. 5. Social Security Number Birthblace (State or Foreign Country) 8. Date of Birth (Month, Day, May 19, 7. Age (In yrs. last birthday) 6. Sex Funeral Days Min. 1964 Months Hours 12M 2DF ΜĎ 236-02-7137 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show the Medical Examinary ust be notified at 1 Yes 2 No Director WV Berkeley Hedgesville with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25427 110 Slumber Lane USA "neturel", or Items 23e Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Item any Injury or other treumatic event, the Madical Examinations. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Tyes 2 No. Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Taxi Driver 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Ann McGowan Jerry W. Johnson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 Slumber Lane, Hedgesville, WV 25427 Diane Bowers sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【\*\*Cremation 3 【\*\*\*Removal from State Dec 14, 2005 Waynesboro, PA Cumberland Valley Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licensee 50 S. Broad St. Waynesboro, PA 17268 23a. Part1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Que to (or as a nsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 | Inpatient 2 | Froutpatient 3 | DOA Other: Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 2 🗆 No 1 Yes 2 Accident after death Director: , 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Funeral Dimpletely filled in 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Yeer) DEC 2 1 2005

stephon

OME, mO

and address of person who completed cause of death (Item 23a) (Type, Print) MO

32. Pojistrar's Signature

20056965

2005

Mabel   Security Number   20736 Emerald Drive   40.01ty Town, or Location of Death   40.01ty Town, or Location   40.01ty Town, or Location of Death   40.01ty Town, or Location   40.01ty Town, or Loca	ace (State or Foreign 1)  and  d. Inside City Limits  1  Yes 2 No  ry?  In Indian,  tc.  ee  ustry  Code)  vn, State  MD  ape1
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Social Security Number   6. Sex   7. Age (in yrs. last plimbout)   10   10   10   10   10   10   10   1	ace (State or Foreign (Y))  1 and  d. Inside City Limits  1  Yes 2 No  ry?  In Indian, tc.  ce  ustry  Code)  wn, State  MD  ape1  21742  Approximate Interval Between
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Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Domestic	code)  vn, State  MD  ape1 21742  Approximate Interval Between
Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Domestic	code)  vn, State  MD  ape1  21742  Approximate Interval Between
Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Domestic	code)  vn, State  MD  ape1  21742  Approximate Interval Between
Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Domestic	code) vn, State MD ape1 21742 Approximate Interval Between
Jesse Joseph Kendall  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20736 Emerald Dr., Hagerstown, MD 21742  20a. Method of Disposition  1	MD ape1 21742 Approximate Interval Between
Jesse Joseph Kendall  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20736 Emerald Dr., Hagerstown, MD 21742  20a. Method of Disposition  1	MD ape1 21742 Approximate Interval Between
Jesse Joseph Kendall  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20736 Emerald Dr., Hagerstown, MD 21742  20a. Method of Disposition  1	MD ape1 21742 Approximate Interval Between
20a. Method of Disposition    Surial   2   Cremation   3   Removal from State   2   Consent   3   Removal from State   4   Constitution   5   Consent   5	MD ape1 21742 Approximate Interval Between
20a. Method of Disposition    Surial   2   Cremation   3   Removal from State   2   Consent   3   Removal from State   4   Constitution   5   Consent   5	MD ape1 21742 Approximate Interval Between
1 Serial 2   Cremation 3   Removal from State   Rest Haven Cemetery   12/16/2005   Hagerstown, M	MD ape1 21742 Approximate Interval Between
Physician //Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to	ape1 21742 Approximate Interval Between
Physician //Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to	21742 Approximate Interval Between
Physician /Medical Examiner  Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death)  Pure 1	Interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a cons	- 2 1225
d	2700
Solve of the part	
	y Day Year
1   Yes 2   No 3   Probably	cause of death?
	bly 4 Unknown
Performed? death?	sy findings available pletion of cause of
To be a consider the constant of the constant	
25. Was case referred to medical examiner?  1	Daughters
27. Manner of Death 1 Senatural 2 Glacident 2 Glacident 3 Glacident 3 Glacident 4 Glacident 3 Glacident 4 Glacident 4 Glacident 4 Glacident 4 Glacident 5 Glacident 5 Glacident 5 Glacident 5 Glacident 6 Glacident 6 Glacident 6 Glacident 7 Glaciden	Residence
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rocality of Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rocality of Town, State)  29a. Certifier (Check only one)  29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 39a. Certif	Route Number,
25. Was case referred to medical examiner?  1	led. he cause(s)
one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)	ay, Year)
Dos 7600 12/14 65	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  22911 Jufferson Bird Smithiburg ND 21733	
State Registrar DEC 2 1 2005	

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. N	ADDE LIBIA
Physician /Medical					ay Year 3. Time of Death
			GATL L. JOHNSON  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lox	DEC. 8	2005 7:35 AM
1	Examir	ner	13520 HERMAN MYERS ROAD HAGERSTO		WASHINGTON
	<sub>o</sub> Funeral Director		5. Social Security Number  217-32-5988  6. Sex 1 Months Days Hours Min.  7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Sex 9. Months Days Hours Min.  1. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 4/3/1936	9. Birthplace (State or Foreign Country)  NEW YORK
21215-0020	/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e-fsh	ctor	MD WASHINGTON HAGERSTOWN		1 ☐ Yes <b>2X</b> No
	ath with the 23e or 28	Funeral Director	10e. Street and Number       10f. Zip Code         13520 HERMAN MYERS ROAD       21742	U	itizen of What Country?
	within 72 hours after death with the Maryland iene. then "netural", or Items 23e or 28e-f show the Medical Examinar routt be notified at	b	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4XXDivorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, specify:  1 □ Yes 2 ▼ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
5-0	netul	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ng 16b.	Kind of Business/Industry
121	within ene. then	ршр	Elementary/Secondary (0-12) College (1-4or 5+) TAX PREPARER		TAX
Maryland 2	be filed tal Hyg d other event,	o Be		(First, Middle, Maide	n Surname)
lary	d 2 should th and Mer 7 Is marke traumatic	-	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rural</i> )		
6, ₹	s 1 and if Health Item 27 other tr		LEE ANN KNICLEY /DAUGHTER 13520 HERMAN MYERS ROA  20a. Method of Disposition (Name of		COWN, MD 21742 Location - City or Town, State
altimore,	00		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State		VINCHESTER, VA
altir	# <b>5 5</b> 5 .		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		INCHESTER, VA
ä	Depa Impo		ROSEDALE FUNERAL HO 917 CEMETERY ROAD		JRG, WV 25401
	Physician /Medical Examiner	ner	23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):	r respiratory arrest,  urc  D. [Ew]	Approximate Interval Between Onset and Death  South
Box 68760,	eath certificate be executed attending physician and for use as the bunal-transit	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):		
B	0 0 0	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacc	o use contribute to the cause of death?
P.O.	± 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Reciplied Arthol Diese.	1 □ Yes	2□ No 3□ Probably 4 Minknown
cords,	requires l been sign should be	Completed by		24a. Was an aut performed?	opsy  24b. Were autopsy findings available prior to completion of cause of death?
<u>~</u>	The ate h	Com		1 □ Yes	2 <b>X</b> No 1 ☐ Yes 2 ☐ No
Vita	Physicien: The rthis certificate ral director, page	Be	25. Was case referred to medical examiner?  Hospital: Other: Othe		
vision	hys his	ation: To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hom	ne 5 X Residence 28d. Describe how inj	6 □Other (Specify) ury occurred
	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	Hospital 24 hours 8 Funeral 1 etely filled	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, at a constant of examination and/or investigation, in my opinion, death occurred and manner stated.		
	To the within 2 To the comple	Me	29b. Signature and title of certifier  29c. License number  29c. License number	29d. D	ate signed (Month, Day, Year)
. 1	W. 12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	\aar := 1 = 1	mh mh
	OH IO Sta Registr		31. Date filed (Month, Par Year) 9 2005 32. Registrar's Signature S. Spark	19gerstol	W17,111D
	A 100 M		I was IN . Williams		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 2, **Physician** ROBERT TOUISSANT JACKSON 2005 11:48 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES COUNTY NURSING & REHABILITATION CIR. LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Months FERLARY 16, 1921 1**₩** M 2□F 84 MARYLAND 213-22-1112 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 le marked other than "neturel", or Items 23a or 28e-f shov treumatic event, the Medical Examinator must be notified at 1 Yes 2 No Director MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 OLD DONCASTER PLACE 20640 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forcee? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If item 27 ie marked other than any injury or other trainment. Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) LUMBERJACK LUMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NOBLE E. JACKSON ROSE POSEY JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED DATCHER / DAUGHTER 2825 LIVERPOOL POINT ROAD, NANJEMOY, MARYLAND 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MT. HOPE CHURCH CEMETERY DECEMBER 7,2005 NANJEMOY, MARYLAND 4 □ Donation 5 □ Other (Specify) Synthesis Fune A Service in english 722 Name and Address of Facility THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JUHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit that initiated events resulting in death) Last certificate be exect Due to (or as a consequence of): Box 68760 attending physician Physician/Medical 950 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No the Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 92 2 No 1 Yes 25. Was case refer en to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Urrsing Home 5 Residence 6 Other (Specify) 2010 2 1 🗌 Yes funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury death. М 1 Yes Hospitel or Attend 24 hours after death Funerel Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Y 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0001009 12-6-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENRY L. BURKE, MD - 115A LA GRANGE AVENUE, LA PLATA, MARYLAND 20646 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 2:28 A M 1. Decedent's Name (First, Middle, Last) °30, **Physician** Prudence D. November Jordan 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Docotor's Community Hospital pital Lannam

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Aug. 29, Prince George's 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1927 Littleton, NH 1 ☐ M 2 € F 003-16-1958 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Prince George's Bowie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Enfeild Chase Court Apt# 274 20716 238 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Iteme 1 ☐ Yes 2/15/No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 24No Specify Specify: White þ 3√Widowed 4 ☐ Divorced 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Private 17 le marked othe traumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) iges 1 and 2 should be fill of Health and Mental Hy Be Donald Jervah Helen Bean P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Delfendahl (Daughter) 6428 Brightlea Drive Lanham, MD 20706 othert Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Important: If eny injury or once. Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/3/2005 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 21. Signature of Funeral Service License 400 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherotz (Arciovascular Disabe **Physician** disease or condition resulting in death) Lans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760, esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by History of Congestiveheart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Steut 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending Injury after death.

Director: Af
I in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the hour within 24 hour To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 0185 rson who completed cause of death (Item 23a) (Type, Print)
DEVORE MS 423 Queensburg Rel Huattsville MS 20781 Name and address of pe 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

rudence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Ruth Ann Kelliher December 3, 2005 5:55 a M /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1928 Blue Ridge Avenue Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F 065-34-4437 65 11, 1940 Director New York Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f ehow Exactiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Direct 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code ō 1928 Blue Ridge Avenue 20902 USA Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be fited within 72 hours after 1 □ Never Married 2√ Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 shourd be successed. Department of Health and Mental Hygient Important: If Item 27 is marked other the any injury or other traumatic event, the Office Manager Non-Profit 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be George Gabak Stephanie Janas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael J. Kelliher/ Husband 1928 Blue Ridge Avenue, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition December 9, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery 2005 4 □ Donation 5 □ Other (Specify) Auburn, New York 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc Tehand I Hales 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Breast Cancer resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. the attending physician by Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe 1 ☐ Yes 2 🖾 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 certificate 1 Yes 2XXNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 \$\ Residence 6 ☐ Other (Specify) 3 DOA ဥ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; After 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide Hospital or within 24 hours a To the Funeral [ pelli 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D53177 40 December 5, 2005

Registrar

State

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seele?

9707 Medical Center Drive, #300, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

2005

06

John Wallmark,

31. Date filed (Month, Day, Year)

			aryland / Depa	artment of Health and rtificate of Death		2005 41220
Physic		1. Decedent's Name (First, Middle, Last)  Juliet E. Kelly			2. Date of Death Month Da	y Yeer 2005 9:58 p M
/Med Exami		4a. Facility Name (If not institution, give street and number) 6248 Rockawalkin Road		4b. City, Town, or Location of Deat Salisbury	h 4c	. County of Death Wicomico
Funeral Director		168-20-7504 1□ M 2□XF	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		
within 72 hours after deeth with the Maryland ane. Then *natural*, or Items 23a or 28a-1 ehow the Medical Examinar must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Wicomico  10e. Street and Number	10c. City, Town or Lo		10g. Ci	10d. Inside City Limits 1 ☐ Yes 2 ☐ No tizen of What Country?
th with 23a or	ai Dir	6248 Rockawalkin Road		21801		USA
ITYIBIIG Z I Z I D-UUJO should be filed within 72 hours after deeth with the Marylan nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f ehow matic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces' 1 Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
Baltimore, Maryiand ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or any injury or other traumatic event, the Medical Exam proce.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give	ident's Usual Occupation is kind of work done during most of wo DO NOT use retired)  Clerk	rking	City Government
IZIC X	To Be Co	17. Father's Name (First, Middle, Last) Herbert Elzie			me (First, Middle, Maider	
Maryla d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) Patricia: A. Kelly/daughter		ing Address (Street and Number or R		
More, IV Pages 1 and 19ent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State	20b. Place of Disponentery, cre	matory or other place)	Date 20c. L	ocation - City or Town, State
Daltimo permit. Pages Department of Important: If i eny injury or once.		*4 □Donation 5 □Other (Specify)  21. Signature of Furreral Service Licen	L	res Mem Park   12/4 2. Name and Address of Facility ewis N. Watson Fu	neral Home	lishury, MD
Physician /Medica Examine		Compatibility list appetitions	d the death. Do not entine.  s a consequence of):  s a consequence of):	618 West Rd., Saller the mode of dying, such as cardia	c or respiratory arrest,	Interval Between Onset and Death
ds, P.O. BOX 68/6U, ires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit.	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	s a consequence of):			
I Kecords, P.O. Box by The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Medi		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that usigned by		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  One of Probably 4 Unknown
	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No
Of VITAL IP Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Other	eath (Check only one)	• Floring (0.1.4.)
on of ding Phys h. After this funeral dir	tion; To	1 Yes 2 No 1039 1 1 Inpat  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ury 28b. Time	ent 3 DOA 4 Nursing	28d. Describe how inju	6 □Other (Specify) ury occurred
Division of VIta With the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the tuneral director.	Certification;	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farm, s atc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
To the Hospital or within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Checklority one) Certifying Physician: To the best and manner and manner is	of examination and/or i	nvestigation, in my opinion, death occ	curred at the time, date an	nd place, and due to the cause(s)
Tot withi Totl	Z	29b. Signature and title of certified	CH	29c. License number	29d. Da	ate signed (Month, Day, Year)
no	)	30. Name and address of person who completed cause of PAVIA T. WALKER.	560	Riverside Pris	Ste AZOG	Salishuey MD
Rogic	tate	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	1		21801

		ı,	1 - For State Registrar	State of M	larylan	d / Depa	artment of rtificate of	Health a		Re	g. No.	)5	41221
	Physici /Medio Examir	al	Decedent's Name (First, Middle, La     Aa. Facility Name (If not institution, given the second	ANAS7	1		4b. City, Town,	or Location of	of Death	100	Day 03 4c. County		3. Time of Death 5:50 A M
	Funeral Director		1/1-24-3105			HOME ast birthday) Yrs.			24 Hrs. 8.	Date of Birth	Year)	9. Birthp	ace (State or Foreign try)
	the Maryland 28a-f show	ector	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgome           10e. Street and Number	∍ry		nsing				16	og. Citîzen of		0d. Inside City Limits 1 □ Yes 2 🛣 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28a-f show entry injury or other traumatic event. The Medical Examinational ponce. Once.	by Funeral Director	4103 Mitscher Con  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1  Yes 2  18 If Yes, Give Year or Dates:	?		20895 Was Decedent of If Yes, specify Cu	ban, Mexicar	i, Puerto Rio	y Yes or No-	USA 14. Rad Bla	ce - Americ ck, White,	an Indian, etc.
21215-0036	d within 72 hou giene. ir then *nature	Completed I	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation	5+)	(Give	dent's Usual Occi kind of work done DO NOT use retir	during mos	t of working	1	6b. Kind of B		dustry
Maryland	should be filed nd Mental Hyg marked othe amatic event,	To Be C	17. Father's Name (First, Middle, Lasi August J. Kulczal 19a. Informant's Name/Relationship	ς		19b. Mailii	ng Address (Stree	Ange	la Fa	First, Middle, M biszews Route Number,	ski		Code)
nore, Ma	ages 1 and 2 nt of Health a t: if item 27 is y or other trau		Martha M. Kolber  20a. Method of Disposition  1  Burial 2 □ Cremation 3 I  4 □ Donation 5 □ Other (Speci	Removal from State	, I	lace of Dispo	Mitsche osition (Name of matory or other pl	ace)	Decemb	per 8	Oc. Location	- City or To	wn, State
Baltimore,	permit. P Departme Importen eny injuri		21. Signature Funeral Service Lice	nsee		F:		ess of Facility	Blvd,	uneral W, Sil	Home ] ver Sp	Inc	MD 20901 Approximate
1,000,	wedical Examiner Itansii the burial-Iransii	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listate or International Cause) that initiated events resulting in death) Last	b. Due to (or as	ine.  Dy Ll  s a consequ s a consequ	uence of):							Interval Between Onset and Death / W UK
P.O. DOX 00/	death certific e attending p id for use as (	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3[	⊒Ectopic pregnan ⊒ Other (specify)	су	11			ite of delive	ry Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions  L. Long term c  2. Hypertension							23e. Did tob			e cause of death
tai Hecc		e Completed	2. Hypertension 5. depression 25. Was case referred to medical		poth	yroid	ism 4.			24a. Was an autopsy perform 1 Yes 2	ed? No	prior to cor death?	osy findings available inpletion of cause of 2 No
Division of Vital Records,	ding Phys h. After this funeral di	Certification: To B	examiner?  1 Yes No  27. Mann of Death  1 Vatural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not I	20	ury a <i>y Year)</i>	ER/Outpatier 28b. Time o Injury	28c. Inj. W	ther: 4 Viu ury at ork? ] Yes 2 []	rsing Home 280 No	5 ☐ Resider	nce 6 □Oth w injury occur	red	
ואוח	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	cai	4 ☐ Homicide determined	hysician: To the besi	t of my kno	wledge, deat	h occurred at the evestigation, in my	time, date an	id place, and	City or Town,	State) use(s) and ma	anner as st	ated. the cause(s)
	To the within 2	Medi	29b. Signature and title of certifier  Church dh  30. Name and address of person who  NURUL CHOWDH  31. Date filed (Month, Day, Year)			23a) (Type.	29c. Licer 29 4	3/2/	n Cal	29	12/03	d (Month, 1)	Day, Year)
	Sta Regist	ate rar	NURUL CHOWDH 31. Date filed (Month, Day, Year) DEC 0 7 2	1005 32 Regist	980/ trar's Signa	Geor ture	gia sve	7 34/	1 211	ver spi	,,,,	11/0	270

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State o	f Maryland		artment of F rtificate of I		d Mental Hy	rgiene Reg. No. 0 0 5	1,1222
	Physici /Medic		1. Decedent's Name (First, Middle Claire S. Kue	, Last) ethe					2. Date of De Month Decemb	er 6, 2005	3. Time of Death 6:40A. M
	Examir		4a. Facility Name (If not institution, 3152 Gracefield	Road, #3	m <i>ber)</i> 05		4b. City, Town, or Silver		eath	4c. County of Death Prince Ge	
	Funeral Director		5. Social Security Number 496-12-7287	6. Sex 1 □ M 2 💢 F	7. Age (In yrs. la 84		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, Da June30	nth 9. Birth Co., 1921 Miss	nplace (State or Foreign untry) SOUri
	ith the Maryland or 28e-1 show	Director	10e. Street and Number	George's	s Sil	, Town or Lo Ver Sj	oring 10f. Zip Code	,		10g. Citizen of What Co	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 23a or 28e-1 show important: If item 27 is marked other than "naturel; or items 23a or 28e-1 show any injury or other treumetic event, tre Modical Exertified; as Item pullified at once.	by Funeral Director	3152 Gracefield  11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Dec	edent Ever in U.S proes? 2 Z.No ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin	? (Specify Yes or No uerto Rican, etc.)	Black, White	ncan Indian,
21215-0036	d within 72 ho piene. r than "natu rre Modical	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (	1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired nemaker	ation during most of f)	working	16b. Kind of Business/l	
and ;	ld be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, I Daniel J. She	ehan				18. Mother's France		, Maiden Sumame) Be <b>r</b> nh	ıardt
Maryland	nd 2 shoul Ith and Me 27 is mari	F	19a. Informant's Name/Relationsh Ralph Kuethe -h							er, City or Town, State, Z	
Baltimore,	Pages 1 ar		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (S)		CR	ace of Dispo	sition (Name of	(e)	Date	20c. Location - City or Alexandria,	Town, State
Balti	permit. Departn Importe any inji		21. Signature of Funeral Service I	Bayer	adt.	<b>B</b> 4	onald Vice 400 Powde	Borgwa r Mill	rdt Funer Road Bel	al Home, PA tsville, Maı	cyland 20705
18760,	cate be executed / Medical Examiner and physician and purial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	Lung ence of):	Carcinom				Approximate Interval Batween Onset and Death 1month
P.O. Box 68	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 13/months? 1 ☐ Yes 21☐ No 9 ☐ Unknown	1 Live t	tcome of pregnar birth 2  Fetal nant at time of de own	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	sigr d be	by	Part II. Other significant condition	ns contributing to d	eath but not resu	Iting in the u	nderlying cause giv	en in Part I.		tobacco use contribute to Yes 2□No 3□Pro	
al Records,		Completed							24a. Was auto perfo 1 🗆 Yes	psy prior to c ormed? death?	topsy findings available completion of cause of
Division of Vital	i or Attending Physicien: The after death.  Director: After this certificate in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? Yes 2 No  27. Manner of Death 1 Natural 5 Pendin investig 3 Suicide 6 Could re	28a. Date (Mon	th, Day Year)	28b. Time o Injury	f 28c. Injun Worl M 1	er: 4 🗆 Nursir	28d. Describe	one)  dence 6 Other (Specific Now injury occurred  Street and Number or Ru	
Divi	F # F C		4  Homicide determ				eet, factory, office		City or To	wn, State)	
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medical one)	Examiner: On the band man	e best of my know asis of examinationer stated.	vledge, deat ion and/or in	vestigation, in my o	pinion, death o	lace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
	To To O	2	29b. Signature and Aftle of contifier	Missiti	In .		29c. Licens DOO4			December 6,	
_			30. Name and address of person Karen J. Merri	t, MD 316	60 Grace	field	Road Sil	ver Spi	ring, Mary	land 20904	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 7	2005 32. F	Registrar's Signat	ure	E)				

DHMH 17 Rev 1/2001

Registrar

QEC 0 6 2005

			1 _ State	Department of Health and Mer Certificate of Death		2000	1.1001
	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)  CEOD CEOD CEOD CEOD CEOD CEOD CEOD CEOD	2.	Reg. No. Date of Death Month Da	ay Year	3. Time of Death
	/Medic	al	GEORGIA L1  4a. Facility Name (If not institution, give street and number)	EE KNIGHT  4b. City, Town, or Location of Death	ecember 40	13 2005 County of Death	13:10 PM
			Citizens Nursing Home	HOVE DE GROCE  inthday) If Under 1 Year   If Under 24 Hrs.   B.	e Pass of Birth	Harton	d
	Funeral Director		5. Social Security Number 6. Sex 7 7. Age (In yrs. last b	Yrs. Months Days Hours Min.	Date of Birth (Month, Day, Year, 8/26/19/	27 Mar	place (State or Foreign ntry) y Land
-	and and		Usual Residence of Decedent         10a. State         10b. County         10c. City, Total	wn or Location			10d. Inside City Limits
	a-f sho	ctor	PA York	Delta			1 ☐XYes 2 ☐ No
	with the	Director	10e. Street and Number	10f. Zip Code		itizen of What Cou	•
	ns 23	erai	634 A Main Street  11. Marital Status   12. Was Decedent Ever in U.S.	17 3 1 4  13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric		ited Sta 14. Race - Ameri	can Indian,
036	urs after o	by Funerai	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Specify: Wh:	
Marvland 21215-0036	and 2 should be filed within 72 hours after death with the Maryland saith and Mental Hygiene.  To its marked other than "natural", or Items 23a or 28a-f show nor traumatic event, the Medical Examinating must be rediffed at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)	16b. H	Kind of Business/In	ndustry
121	e filed within all Hygiene. other than vent, the we	Con	11 17. Father's Name (First, Middle, Last)	Salesperson 18. Mother's Name (F		Retail :	Sales
lanc	2 should be f and Mental b is marked of raumatic eve	То Ве	Campton C. Bailey		M. Russ		
Mary	12 sho h and h 7 is ma trauma			ab. Mailing Address <i>(Street and Number or Rural R</i> 634 A Main Street,			o Code) 3 1 4
	ges 1 and 1 of Healt If item 2 or other		20a Method of Disposition 20b. Place	of Disposition (Name of Date		ocation - City or To	own, State
Baltimore	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.		'4 □ Donation 5 □ Other (Specify)  21. Signator of Funeral Service Licensee	22. Name and Address of Facility			
<u>~</u>	1 89 E 8 9		23a Part I Enter the disease, or complications that caused the death. Do shook, or heart failure. List only one cause on each line.	Harkins Funeral onot epter the mode of dying, such as cardiac or re		nc., Dei	Approximate Interval Between
	Physician /Medical		formediate Cause (Final disease or condition resulting in death)	UteroVarian			Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate	1 CAD			
V	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events				
8760	icate be executed physician and the burial-transit	dical Ex	resulting in death) Last  Due to (or as a consequence d.	э of): Д			
C)	ertificat ing phy e as th	Medi	IF FEMALE:				
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
// C	quires that n signed build be deta	d by Pr	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.			the cause of death?
2019	The law requir ate has been si page 2 should	Completed by			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Vita S	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (0			
+ 0	Attending Physician: r death. ector: Atter this certific by the funeral director,	n; To	27. Manner of Death 28a. Date of Injury 28b	Dutpatient 3 DOA 4 Nursing Home	5 Residence d. Describe how inju		<u>fy)</u>
Sign	or Attending I after death. Director: After in by the funer	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	f. Location (Street a	and Mumbos or Dur	al Davida Alumbar
Solving	- Fife	Certification;	4 Homicide  determined  determined  28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	City or Town, Stat		ar Houte Number,
	To the Hospital or within 24 hours afte To the Funeral Dirk completely filled in the complete of the complete	edical	29a. Certifier (Check on) 2 Medical Byaminer: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred	at the time, date an	nd place, and due t	o the cause(s)
•	Tot with Tot com	Σ	29b. Signature and title of certifier	D 00 6 2 90		ate signed (Month,	Day, Year)
-	6		30. Name and address of person was completed cause of death (Item 23a)		lavre de	Grace	c. MB
	St. Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 1 9 2005  32. Tegistrar's Signature	Sparles	•	•	

			For State Registrar	State of M	aryland	•	rtment tificate			and M		jiene	005	1.1000
14	Physici		1. Decedent's Name (First, Middle, La: Horace	Т.		King					2. Date of Dea Month	th Day	Year	3/Time of Death
*	/Medio Examin	nder .	4a. Facility Name (If not institution, given Calvert Memor	ial Hosp	pital			nce	Fre	der			Calv	ert
	Funeral Director		5. Social Security Number 6. S 216-18-5333 13 Usual Residence of Decedent	ex 7. Aç ☐XM 2☐ F	ge (In yrs. Ia 86	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Day Mar. 2	0,19	9. Bin Co 19 Ma	thplace (State or Foreign buntry) aryland
	72 hours after death with the Maryland neturel; or Iteme 23a or 28a-f ehow diest Exeminer mart be notified at	ector	10a. State 10b. County  Maryland Calv	ert	10c. City	, Town or Lo	usby					0.0	n of What Co	10d. Inside City Limits 1 Yes 2 No
	ath with t	Funeral Director	50 Appeal La					206					USA	
036	be filed within 72 hours after death with the Marylar lat Hygiene. Id other then "heturel", or Iteme 23a or 28a-f ehow event, the Medical Exeminating must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Yes 24 If Yes, Give Year or Dates:	?		Vas Decedei Yes, specify I□Yes 2[			gin? (Spei , Puerto F	offy Yes or No- lican, etc.)	1	Black, Whit	
21215-0036	within 72 hc ene. then "netur he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give life. l	lent's Usual ( kind of work DO NOT use k Dr	doné di retired)	<i>iring</i> most	of working	g		of Business nsfer	Industry
and 2		Be	17. Father's Name (First, Middle, Last,  John Albe		King					r's Name	(First, Middle,	Maiden Su Evel		Stewart
Maryland	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic	2	19a. Informant's Name/Relationship ( Rachel Smith/s	Type, Print)			g Address (S		nd Numbe	r or Rural	Route Number	r, City or To	own, State, 2	Zip Code)
Baltimore,	ë ° = 5		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Ce	ace of Dispo emetery, cren Johr	sition (Name	of er place	)	Di	ate	20c. Locat	by, M	Town, State
Balti	permit. Per Department Important: any injury once.		21. Signature of Funeral Service Licer	Sewell	,						vell F			ome ed.,MD2067
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying	plications that cause one cause on each late a.  Due to (or as Due to (or as Due to (or as Due to (or as C.	ine.  aclus s a consequ	J+ /	41×15	do	7	dis?	respiratory arr		me	Approximate Interval Between Onse and Peath
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	icai Examine	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as			امد ر	als.	x67	2				
P.O. Box 68	death certific e attending p od for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic preg Other (spec					23d	l. Date of del Month	ivery Day Year
	quires that the signed by ald be detacted	by	Part II. Other significant conditions of	ontributing to death I	but not resu	Iting in the u	nderlying cau	ise give	n in Part I.		23e. Did to		_	o the cause of death?
Il Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was a autops perform	sy	4b. Were au prior to death? 1 \sum Yes	itopsy findings available completion of cause of
n of Vital	iding Phyeician: 1 th. After this certifical funeral director, p	To Be	25. Was case referred to medicat examiner? 1 Yes 2 PMo  27. Manner of Death 1 Matural 5 Pending	Hospital: 1 Propati		ER/Outpatier 28b. Time of Injury	280	. Injury Work	<sup>C</sup> 4 □ Nu at ?	rsing Hom	(Check only on the 5 ☐ Reside 8d. Describe he	ence 6		cify)
Division	or Attendation director in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Ir	niury - At horitic. (Specify	me, farm, str	eet, factory, o		es 2 🗆 i		8f. Location (Si City or Town	treet and N n, State)	lumber or Ru	ural Route Number,
	the Hospital hin 24 hours the Funeral upletely filled	Medical C	29a. Certifier 1 2 ertifying Pr (Check only one) 2 Medical Exam	sysician: To the best niner: On the basis and manner s	of examinati	wledge, death ion and/or in	occurred at vestigation, in	the time	e, date an inion, dea	d place, a th occurre	nd due to the c d at the time, d	ause(s) an late and pla	d manner as ace, and due	stated. to the cause(s)
)	vithii To th	×	29b. Signature and title of perfitter	7	000	_	29c. l	License J	number 3 9	رکی	2	9d. Date s	igned (Mont	1. Day, Year) 266
16	<b>4</b>	ate -	30. Name and address of person who I Feev S  31. Date filed (Month, Day, Year)	1(0 Kg	spe 2	ure	Print)	ps.	r. Fi	re de	rich	MA	(B)	20675
Di	Regist	rar	DEC - 7 2005	Bearing &	the State of	and o						•		

	To the Ho within 24 To the Fu completel	
31	1-8H	
	Regis	:

		Please Type or Print in Black In  State of Maryland / Dep  State Registrar  Ce		lental Hygie	<b>20</b> 05	1,1226
		1. Decedent's Name (First, Middle, Last)	Timodio of Death	Reg. 2. Date of Death	NO.	3. Time of Death
Physicia		Thomas Luther Lewis Jr.		Month Decomiser	Day Year	2300 M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
البالله المالية		Washington County Hospital	Hagerstown		Wachingt	on Country
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth (Month, Day, Ye	9. Brith	on County blace (State or Foreign ntry)
Director		220–16–3101 1X□M 2□F 80 Yrs.		October 3	1925 Ma	ryland
3	}	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L.	ocation			10d. Inside City Limits
o da	5		agerstown			X□Yes 2□No
28a-	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
ag or		262 Hager Street	21740			
ms 2:	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	can Indian,
or its		1 Never Married 2 Married   Armed Forces? 1 Nover 2 No 12-7-43	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Hican, etc.)	Black, White,	
Eve	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 4-8-46	Tes 223 No Specily.		Specify: VVII.	
natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation  kind of work done during most of work		. Kind of Business/fr	idustry
ne. han	m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
Hygie ther t nt, th		8. C 17. Father's Name (First, Middle, Last)	ustodian 18. Mother's Nam	e (First, Middle, Maid	oard of Ed	ducation
od o	) Be	Thomas Luther Lewis Sr.				
nd Me mark mati	ပို		ng Address (Street and Number or Rur	L. Keets al Route Number, Ci		Code)
ith ar 27 is r treu		Barbara Diane Lewis (wife) 262	Hager Street Hage	rstown Ma	rvland 21	740
f Hea item othe		20a. Method of Disposition 20b. Place of Disposition			Location - City or T	
ont: if		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	wn Mem Park   12-1	2-05 Ha	agerstown	Maryland
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Exeminer must be notified at once.		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Do	uglas A. I	Fierv Fune	eral Home
Depa impo eny ir						
.b. =		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one on secon each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	SCOMI PMI	Interval between
hysician		Immediate Cause (Final disease or condition	g com	01		2 m cont
Medical		resulting in death)  Due to (or as a consequence of):			C	XVIIIV
xaminer		Sequentially list conditions, b				
si	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
and I-tran	Examin	resulting in death) Last C. Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·			
sicien and burial-transit	- CE					
phys s the	ician/Medic	d				
nding use a	/W	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
d for	cia	in the past 12 months?  1 Ves 2 No.  1 Ves 2 No.	□Ectopic pregnancy □ Other (specify)		Month	Day Year
by the	Physi	9 Unknown				
ned l	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
en sig	pe	Chranic obstructive pul	rmoundh gizeas	Yes	2 No 3 Pro	pably 4 □Unknown
2 sho	Completed	\\		24a. Was an autopsy		opsy findings available impletion of cause of
ate ha	mo;			performed	l? death?	
ertific ctor,	Be (	25. Was case referred to medical examiner?		h (Check only one)		
his ca	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatie		ome 5 Residence		fy)
After 1 unera	ii ii	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐Natural 28b. Time of Injury	Work?	28d. Describe how is	njury occurred	
death tor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury. At home farm of	M 1 Tes 2 No	28f. Location (Street	tand Number or Pur	al Pausa Numbas
etter Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	City or Town, S.		ar Addie Namber,
ours neral filled		29a. Certifier 4 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the cause	e(s) and manner as s	stated.
within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due t	o the cause(s)
within To th	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		Hind House do	MA DUL	472	12/8	100
		30, Name and address of person who completed cause of death (Item 23a) (Type	, Print)	11		103
-841		Hind Houndon, MD.	1130 OPAL C	T! HO	gentow	N, ND 21740
Sta		81. Date filed (Month, Day, Year) 32. Registrar's Signature   CEC 1 2 2005	1. 4.	1	J	7
Registr	ar	ULU I a 2000 Marsen D. p	parasa			

		For State	State of Maryland /		artment of Health and I rtificate of Death	-	-	P*40 # 4
	-	Registrar  1. Decedent's Name (First, Middle,	(ast)	Ce.	incate of Death	2. Date of De	Reg. No.	3. Time of Death
Physic	ian		LEATHERMAN			Month	Day Ye	4.4
/Medi Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of Deat	Decemb	4c. County of D	
ZX		REEDERS MEMORI	AL HOME		BOONSBORO	)	WA	SHINGTON
Funeral Director		5. Social Security Number 218-50-3854	. Sex 7. Age (In yrs. last 1 ☐ M 2 X F 93	birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		th Yea 1912	Birthplace (State or Foreign
p ,		Usual Residence of Decedent	10c. City, To	um or l	rection			10d. Inside City Limits
the Maryland 28a-f show multified at	ō	10a. State 10b. County MARYLAND WAS:	HINGTON	JWII OI LC	SHARPSBURG			1 Tes 2 No
the M	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	
th with 23a or	ā	5418 SHARPSBURG	PTKE		21782			S.A.
ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	Specify Yes or No		American Indian,
nus after death with al', or Items 23a or Examinar must be	교	1 Never Married 2 Marrie	Armed Forces?  1  Yes 2 XNo If Yes, Give	j		to Rican, etc.)		Vhite, etc.
hours a tural', c	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 💢 No Specify:		Specify:	WHITE
"na	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	16b. Kind of Busin	ess/Industry
illed withly Hygiene. other than	mo.	8			HOMEMAKER		OW	N HOME
8 E 8	Be (	17. Father's Name (First, Middle, L.					, Maiden Sumame)	
should be find Mental Barmarked of	2	RALEIGH ABRAHAM				TTA MYEF		7-0-4-1
		19a. Informant's Name/Relationshi SHARON A. COULTE			ng Address (Street and Number or Ri + LYLES DRIVE, HA			
s 1 a of Hei item item		20a. Method of Disposition			osition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Pages nent of I ant: If it		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		CAIN	VIEW CEM. 12/1	3/2005	SHARPSBU	RG, MARYLAND
permit. Pages 1 ar Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service C	censee		2. Name and Address of Facility  BAST FUNERAL HOME		OLD NATION	
		23a. Part1. Enter the disease, er c shock, or heart failure. List o	perplications that caused the death. D	o not en	ter the mode of dying, such as cardia	c or respiratory a	SORO, MARY	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Brall	i Co	ncer			2 months
/Medical		resulting in death)	Due to (or as a consequence	•				
Examiner	L	Sequentially list conditions,	b					
ed isit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce o1):				
xecut and II-tran		that initiated events resulting in death) Last	c	ce of);				
ificate be exec g physician an	cai Ex		d.	, ,				
tificat ig phy as thi	ledi							
Attending Physician: The law requires that the death certificate be executed r death. Securificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3[	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
nat the de d by the letached	hys	9 🗆 Unknown	9□ Unknown		-			
aician: The law requires that certificate has been signed br rector, page 2 should be det	d by	Part II. Other significant condition	s contributing to death but not resulting Dementia Seni/ity	g in the u	inderlying cause given in Part I.		٠	te to the cause of death? ] Probably 4 []Unknown
sw rec s bee	olete		Senility'			24a. Was	an 24b. Wer	autopsy findings available
The lav ate has page 2	Com					auto perfo	propried? deat	
yalcian: The is certificate hidirector, page	Be (	25. Was case referred to medical examiner?				ath (Check only o		
Phyaid this or al dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/				dence 6 Other (	Specify)
ding P	on:	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	o. Time o Injury	Work?	28d. Describe	how injury occurred	
o the Hospital or Attending Physithin 24 hours after death. o the Funeral Director: After this ompletely filled in by the funeral di	Certification:	2 Accident investigated as Suicide 6 Could not determine	t be	, farm, st	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location ( City or To	Street and Number own, State)	r Rural Route Number,
Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying	Physician: To the heat of my knowled	dae des	h conversed at the time, date and also	and due to the	cause(s) and mann	r as stated
the Hosp hin 24 ho the Fune npletely f	edicai		Physician: To the best of my knowled kaminer: On the basis of examination and manner stated.					
	(0)				29c. License number		29d. Date signed (M	

To the Hospil
within 24 hour
To the Funer
completely fill

OH-4

State Registrar

Dr. Zafar Malik 2 31. Date filed (Month Pay Year) 2005

29c. License number D 4 4 9 9 6

29d. Date signed (Month, Day, Year)
December 10, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20311 Lappans Road, Boonsboro, MD 21713 / 301-432-8470

5 Jacks Signature

			For State	State of Ma	aryland ,		artmer			ind Me		giene Reg. No. 00	5	4122	2.8
1	24 8		Registrar  1. Decedent's Name (First, Middle, Last)							2	Date of Dea			3. Time of D	Death
4	Physici			Lone							Month Decemb	er 2, 20	Year 005	1:23	a <sub>M</sub>
. *	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of		Decemb	4c. County		1.25	
	Examili	Ç.	151 Ritchie Avenu	e			Si	lver	Sprin	ng		Mont	gome	ery	
	Funeral		Social Security Number 6. Sex	-	(In yrs. last	birthday)	If Unde	r 1 Year	If Under 2		Date of Birt (Month, Da	h V Vearl	9. Birthr	place (State or	Foreign
	Director		215-20-2849	M 2[X]F	81	Yrs.	Months	Days	Hours	Min. Ma	arch 2	7, 1924	Mar	yland	
	D		Usual Residence of Decedent		10s City T	`								IOd Incide City	. 1 : : : -
	arylar	_	10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City 1 ☐ Yes	
	8a-f	Director	Maryland Montgom	ery	Sil	ver S						10- 01	11		
	with t	Dir	10e. Street and Number				10f. Zip					10g. Citizen of W		ntry r	
	s 234	Funeral	151 Ritchie Avenu	.e 12. Was Decedent E	Ever in II S	12 \		910	enanie Orio	in? /Specif	fy Yes or No		JSA a - Americ	can Indian,	
	item	Ľ,	11. Marital Status  1 Never Married 2 Married	Armed Forces?		13.	f Yes, spe	cify Cuba	n, Mexican,	, Puerto Ric	can, etc.)		k, White,		
336	irs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 <b>]</b> No	Specify:			Specify	Whit	e	
Ģ	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f show the Medical Exaudier must be molified at	ted	15. Decedent's Edu		1	6a. Dece				-6		16b. Kind of Bu	siness/In	dustry	
215	hin 7	pje	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT		luring most )	or working					
2	giene giene	Completed	9			Man	ager			<u>-</u>		School	Cafe	eteria	
ng	al Hygie d other	Be (	17. Father's Name (First, Middle, Last)									Maiden Sumam	в)		
yla	Men Men arke	၉	Charles C. Reed								le All				
Maryland 21215-0036	od 2 shall hand lith and 27 is m		19a. Informant's Name/Relationship (Ty Joyce Seamens/ Da				-					or, City or Town, pring, N			
Baltimore,	of Hea		20a. Method of Disposition  xt Burial 2 Cremation 3 A	lemoval from State	20b. Plac	e of Dispo etery, crer	sition (Na natory or o	me of other plac	θ) [	Dat Decemb		20c. Location ·	City or To	own, State	
<u>Ë</u>	Line Hand		4 ☐ Donation 5 ☐ Other (Specify)		Fort					200		Brentwoo		Maryland	đ
Ball	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 is marked other t any injury or other traumatic event, III once.		21. Signature of Funeral Service License	وما		F 5	ranci 00 Ui	od Addres IS J. niver	s of Facility Coll sity	ins E Blvd,	Tunera W, S	l Home l ilver Sp	inc oring	, MD 2	0901
Į,	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused	the death. I	Do not ent	er the mod	de of dyin	g, such as	cardiac or r	espiratory ai	rest,		Approximate Interval Betw	een
	Physician		Immediate Cause (Final disease or condition	a Alzheime	ria D	icasc	_							Onset and De	aath
经	/Medical		resulting in death)	Due to (or as											
	Examiner			Sepsis											
	sit ad	lne	Tary, lagoing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		ice of):									
	and and I-tran	Examine	that initiated events resulting in death) Last	Dehydrat  Due to (or as		ice of):	_		_				-		
8760,	ate be executed hysician and the burial-transit	aiE				,									
687	ate the	edicai		d											
	death certific e attending pl od for use as f	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23d. Dat	e of delive	erv	
Вох	atter for u	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic p Other (s					Mor		,	ear
0	t the de by the tached	nysi	9 Unknown	9□ Unknown											
S, P	g g g	by Pi	Part II. Other significant conditions con	ntributing to death b	ut not resultir	ng in the u	nderlying	cause give	en in Part I.		23e. Did t	obacco use contr	ibute to t	he cause of de	ath?
rds	quires an sign uld be									_	10	res 2∄No	3 🗌 Prot	oably 4 □Ur	nknown
of Vital Record		Completed									24a. Was		Vere auto	ppsy findings a	vailable
æ	The te h age	E									autor perfo	rmed?	leath?		n29 OI
ita	ian: '	0	25. Was case referred to medical						26. Place	of Death (	Check only o				
f V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐xNo	Hospital: 1 🗌 Inpatie	ent 2 EA	VOutpatier	nt 3 D	OA Othe	er: 4 ☐ Nu	rsing Home	5 ∏ Resid	dence 6 Othe	эг (Ѕрөсіі	<i>(y)</i>	
			27. Manner of Death 1-□ Natural 5 □ Pending	28a. Date of Inju (Month, Da)	ry 28 y Year)	3b. Time o Injury	f	28c. Injury Work	at c?	28	d. Describe l	now injury occurr	ed		
Si.	Attending r death. ector: After by the fune	atic	2 Accident investigation		1		М	1 🗆 '	Yes 2 1	No					
Division	or Attendate after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc.	ury - At home c. (Specify)	e, farm, str	reet, factor	y, office		28	f. Location (S City or Tox	Street and Numbi vn, State)	ar or Rura	al Route Numb	er,
_	pita ours ours iiile	edical C	(Check only 2 Medical Exami	sician: To the best											
	To the Hos within 24 h To the Fur completely	Medi	29b. Signature and title of certifier	and manner sta				c. License				29d. Date signed			
N .			661,14	1/1/	MA	Do.	6.	`	210	1		15 /-	~		
,	3	1	30. Name and address of person who or		looth (lize = 2	4/6	6	100	2/73	54		12-5-	05		
		-			12164	I C	ent	val.	Ave.	# 21.	2 mi	tchellvi	IP N	10 20-	721
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur		again.	8			1	10010101	, "		1 1
-	Regist		DEC 072	005	is so	M	10 20 W								

	1	State Registrar				Cei	rtificat	te of l	Death			Reg. No	. U		4166
		I. Decedent's Name (First, Midd	dle, Last)								2. Date of I	Death Da		Year	3. Time of D
ician dical		Ruby Car	olyn	Lewis	3						11		Ö	05	2132
niner		a. Facility Name (If not institution	on, give stree	et and numbe	or)		4b. City,	, Town, or	Location of	of Death		40	. Coun	nty of Death	
		118 Onond	aga D	rive			For	est	Heid	rhts			Pri	ince	George
al	5	5. Social Security Number	I C CAY	7	Age (In yrs.	last birthday)	If Unde Months	r 1 Year	If Under	Min.	B. Date of I	Birth Day, Year		9. Birth	hplace (State or untry)
		Unknown	1 U M	2□F //	-61	Yrs.						19-4			VA
1	-	Usual Residence of Decedent  10a. State 10b. Count			10c Cit	ty, Town or Lo	cation								10d. Inside City
_		Tod. State	У		100.01	ty, TOWITOI LC	cation								1 TYes 2
ctc	<u> </u>		ce Ge	orges	F	orest			S						n
Dire		10e. Street and Number					10f. Zip	p Code				10g. C	tizen o	of What Co	untry?
by Funeral Director	<u> </u>	118 Onondag	a Dri	ve			<u> </u>	207				Uni	tec	Sta	ates
une	1	11. Marital Status		Was Deceder Armed Force	s?	J.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Ori in, Mexican	gin? (Spec , Puerto R	ify Yes or ican, etc.)	No-		ace - Amer lack, White	rican Indian, e, etc.
<u>-</u>		1 Never Married 2 Ma		1 ☐ Yes 2 ☐ If Yes, Give			1 ☐ Yes	2 <b>⊠</b> No	Specify:				Spec	cify:	
d b	3	3 ☐ Widowed 4 ☐ Divorce	,	Year or Dates	S:	. 1									ack
Completed		15. Decede (Specify only high	int's Education est grade co	on ompleted)		16a. Dece	kind of wo	ork done o	durina mos	of workin	g	16b. f	(ind of	Business/I	Industry
100	_	Elementary/Secondary (0-12)	-	College (1-4o	or 5+)	life.	DO NOT u	ise retired	"						
ြ	5 -	12		5+		Sch	nool	Tea	cher						hools
B		17. Father's Name (First, Middle	, Last)						18. Mothe	r's Name	(First, Midd	lle, Maide	n Sumi	ame)	
ျ	2	Frank Chess	on.	Jr.					Ar	leli	a La	ng			
		Frank Chess 19a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailir	ng Address	s (Street a					or Tow	m, State, Z	(ip Code)
		Marrin Chace	an/B	ratha	r	301	Pro	vide	nce	Road	Ch	esa	ea	ke,	VA 233
-	2	Marvin Chess 20a. Method of Disposition				Place of Dispo	sition (Name	me of other plac	e)	Da	ite	20c. L	ocation	n - City or 1	Town, State
		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (		oval from Sta	te	nesape	•	•	1	2 06	-05	Pol	+ ~		O MD
	-					TESTDE	are.	CLE	s of Facilit	Z-00	-05_	Del	LD	$\Lambda T T T$	C/ IID
sól	- 13	<ol> <li>Signature of Funeral Service</li> </ol>	e Licensee		1	1 22	<ol><li>Name a</li></ol>	na Adares						-	- '
al ar		23a. Part1. Enter the disease, chock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complicati st only one c	ause on each Ather	line.	th. Do not enterosis	ter the mod	ALLE de of dyin	g, such as	n RC cardiac or	respiratory	arrest,	Sp	eral ring	Servi S, MD2 Approximate Interval Betwe Onset and De
		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complicati st only one c	Ather Due to (or a	oscl	th. Do not enteresting erosis	ter the mod	ALLE de of dyin	g, such as	n RC cardiac or	respiratory	arrest,	Sp	eral ring	Approximate Interval Betwee Onset and De
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend Item #31 per DVR State of Maryland / Department of Health and Mental Hygiene Amend Item #5 Certificate of Death WCHD/SH 12/9/05 per FH 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day 1005 pm **Physician** 105 Miller 12 Konnie /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Hagerstown, MD Washington MIA Manor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 100 M 20 F **Funeral** Yrs Director Jan 26 1941 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at N☐ Yes 2 ☐ No Directo Washington Hagerstown Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Funerai 21740 USA 106 S. Mont Valla Avenue 12. Was Decedent Ever in U,S. Armed Forces? XXYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 If Yes, Give 1963-69 1 ☐ Yes 2 ☐ No Specify. Specify: δ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) College 0 Maintenance th and Mentel Hygie 7 Is marked other th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flik Department of Health and Mentel Hy Important: If Item 27 Is marked othwanty any Injury or other traumatic event Mary Charlotte Stoner Samuel Levi Miller 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 S. Mont Valla Ave., Hagerstown, Md. 21740 <u> Fay Miller - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/10/05 Frederick, Maryland Mt. Olivet Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 alu 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Preumonia Examiner Due to (or as a consequence of): Chorea Dysphasia, GERD Physician/Medical Examiner The law requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Deophagitis Due to (or es e consequer Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ğ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 1 Yes 2 No 4 ✓ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier south 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) opal court, Hazerstown MD21740 CRNP Sarala 1126 31. Dete tiled (Month, Day 1997) 2005 Registry's Signature State Registrar

DHMH 16 Rev 6/95

			For State Registrar	State of M	aryland		artment <i>tificate</i>			and Me		giene Reg. No.	005	41231
	Physicia	an	Decedent's Name (First, Middle, L Freda	Last) Malech							2. Date of De Month Novem	ath Day	7, ŽÔÔ	3. Time of Death 5 3:05P M
	/Medic Examin	al	4a. Facility Name (If not institution, g		r)		4b. City, T	own, or	Location o	of Death		-	ounty of Dea	
	Examin	C.	8213 Beech Tree				Beth	nesda	a			M	ontgom	erv
	Funeral				lge (In yrs. Ias	st birthday) Yrs.	If Under 1 Months		If Under :	24 Hrs. Min. Nr	8. Date of Bir DV • 6 •	th	9. Bir	thplace (State or Foreign ountry) Jersey
	Director		Usuaf Residence of Decedent	- A		113.		1		111	37. 0,	1717	New	Jersey
	how		10a. State 10b. County			Town or Lo	cation							10d. Inside City Limits
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5	Phys this raldi	To	1 Yes 2 No 27. Magner of Death	1 ☐ Inpa 28a. Date of In	itient 2 El	R/Outpatier 28b. Time of		A Othe Bc. Injury Work			ne 5 ☐ Resi 8d. Describe			on s edy Residence
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Division	Hospital or Attending     24 hours after death.     Funeral Director: After etely filled in by the funer	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 289. Prace of I	iniury - At hometc. (Specify)	ne, farm, str	eet, factory,	office		2	8f. Location ( City or To		Number or R	ural Route Number,
_	pital c	S	29a. Certifier 1 X Certifying	Physician: To the bes	at of my knowl	ladas dasti		a the tim	o dato an	d plane a	ad due to the			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Ex	caminer: On the basis and manner:	of examination	on and/or in	vestigation,	in my op	inion, dea	th occurre	d at the time,	date and p	lace, and du	e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1. 4		14 6		License	number			29d. Date	signed (Mon	th, Day, Year)
	20		> Michael a	. Wester	min,	M.D.	I	0524.	51		1	Novem	ber 28	, 2005
			30. Name and address of person w					16 1	Vonat	nata	n, MD	20801	_2216	
	Sta	ate	Michael A. We 31. Date fifed (Month, Day, Year)	32. Regis	strar's Signatu	re /	AND D	.0, 1	CEHS I	ing co.	LL, FID .	20071	2310	
	Regist		DEC 0 6 2	1005 Man	w the	A STATE OF	The state of the s							

			For State Registrar		Maryland / D	)epar		of Heal	lth ar			e 200	·	1232
į.	Physici	an	Decedent's Name (First, Middle, L     Anthony P. Mos		<u> </u>					2. Date of	nhe R	ey2 '24'9	3. Tir	ne of Death
	/Medic Examin		4a. Facility Name (If not institution, gi		θr)		4b. City, To	wn, or Loca	ation of [	Death	4	c. County of D	eath	1 / / / / / /
5	Lxaiiii	CI	Doctors Commun				La	anham			E	rince (		's
	Funeral Director	0	5. Social Security Number 6. 577–42–0849 Usual Residence of Decedent	Sex 7. 1□XM 2□ F	Age (In yrs. last birt		If Under 1 \ Months D		Jnder 24 ours	Min. 8. Date o (Month)	f Birth , Day, Yea 17,19	9.1	Birthplace (Si Country) Dhio	tate or Foreign
	/land		10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Insi	de City Limits
	e Mar	ctor	MD Prince C	eorge's	Во	wie							¹X	Yes 2 No
	death with the Maryland me 23a or 28a-f show rmust be notified at	Director	10e. Street and Number				10f. Zip Co				10g. C	itizen of What	Country?	
	ne 23	Funeral	3525 Moylan Dr	12. Was Decede	ent Ever in U.S.	13. Wa		20715 t of Hispan	nic Origin	n? (Specify Yes o	r No-	USA 14. Race - A	merican India	an,
036	hours after of tural; or iter al Examinar	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	ZV0		Yes, specify □Yes 2[ <mark>7</mark>		exican, F ecify:	n? (Specify Yes o Puerto Rican, etc.	)	Black, W Specify:	white, etc.	
21215-0036	be filed within 72 hours after death with the Marylar ital Hyglene. d other than "natural", or iteme 23a or 28a-f showers. The Madical Examiner must be nailfied at	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4	or 5+)	(Give kii life. DC	nt's Usual Cond of work of NOT use i	done during etired)	g most o	f working		Kind of Busine		
2	filled v Hygie other t		17. Father's Name (First, Middle, Las	5+		ECO	HOULE		Mother's	Name (First, Mi		ept. of	uie iv	avy
<u> a</u>		To Be	Peter Moskios					Aı	ngel	iky Ligo	uris			
Maryland	and and is m	-	19a. Informant's Name/Relationship		1					or Rural Route N	ımber, City	or Town, State	e, Zip Code)	- 1
	thealth Item 27 other tra		Alex Moskios /	brother	35 20b. Place of		Moylar		ve	Bowie,		20715 Location - City	or Tour Cto	10
n D	000		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		cometan	y, crema	atory`or othe	r place)	12	/5/2005		apolis		.te
altimore,			21. Signature of Funeral Service Lice		1 St. De					Beall Fu			, ML).	
ñ —	permit Depar Impor any in		- Brian	Pouce	el .	65	12 NW	Crain	n Hw	y. Bow	rie, M		715	
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	one cause on eac	sed the death. Do not help as a consequence of	J	r the mode o	1	ch as ca	rdiac or respirato	ry arrest,			kimate il Between and Death
68/60,	Examination and burial-transit	dical Examiner	Sequentially list conditions, if any, seauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (ur	as a consequence of	Ca.								
HOX	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death		Ectopic pregr Other (specia				_	23d. Date of Month	delivery Day	Year
, P.O.	es that I igned by be deta	by Ph	Part II. Other significant conditions							23e. l	Did tobacco	use contribute	to the cause	e of death?
Sig	w require been sig should b	ted t	Auto M.	1000	r el al	1	V 1/6	-61	47		Yes :	2 No 3	Probably	4 Donknown
I Records,	: The law r cate has be page 2 sh	Completed								a	Was an autopsy performed?	prior death	to completion	
Vital	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, a C 50/0		3□ DOA	Other		Death (Check o				
Division of	Attending Physician: or death. ector: After this certification in the funeral director.	-	27. Manner of Death  1 Aatural 5 Pending 2 Accident investigation	28a. Date of (Month,	njury 28b. T			Injury at Work?				6 LiOther (S	pecity)	
Divis	ospital or Attend hours after death uneral Director: v ly filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of	Injury - At home, far , etc. (Specify)	rm, stree	et, factory, of	ffice	-		on (Street a Town, Sta	and Number or te)	Rural Route	Number,
	To the Hospital or A within 24 hours after To the Funeral Directon Disease of the Funeral Directon Disease of the Funeral Directon Disease of the Funeral Directon Di	edical	29a. Certifier 1 Lertifying P	hysician: To the be miner: On the bas and manne	est of my knowledge, s of examination and r stated.	, death o	occurred at t estigation, in	he time, da my opinior	ate and p	place, and due to occurred at the ti	me, date ar	nd place, and c	lue to the cau	
	To t To t	Σ	29b. Signature and title of certifier	of 1	M-2			icense num		1		ate signed (Mo		ar)
2	7		30. Name and address of person who		of death (Item 23a) (	Type, Pr	rint) = 1	ورره	~ \ \ e	P	Lan	hem 1	no 2	0706
430	Sta	te	31. Date filed (Month, Day, Year)									,		
	Registi		DEC 0 6 2005	Black	istrar's Signature	ode								

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of He rtificate of D	eath	Reg	g. No. UUD	41233
y.	Physici	an	Decedent's Name (First, Middle	, Last)				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Medic		ROBERT	F.	MOC			Vovember	30 3005	7:11 P M
77 A	Examin	er	4a. Facility Name (If not institution			4b. City, Town, or L	ocation of Death		4c. County of Death	
2. 3.27 (42)	Funaral	1 mg	DOCTORS COMMUNI  5. Social Security Number		Age (In yrs. last birthday			8. Date of Birth	PRINCE GEO	DRGE  uplace (State or Foreign untry)
	Funeral Director		714-14-0310	1 <b>K</b> ] M 2□ F	90 Yrs.	Months Days	Hours Min.	(Month, Day, 1 09-05-19		RGIA
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Marylan -1 show	to	MD PRINCE	GEORGE	UPPER MAR	RLBORO				1X□Yes 2□No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?
	th with	ai D	11907 WIMBLETON	STREET		20774			U.S.A.	
	dea	Funerai	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.S. 13. es?	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	72 hours after death with the Maryland natural; or items 23s or 28s-1 show Leal Evanumer was be motified a	by Fu	1 ☐ Never Married A ☐ Marr 3 ☐ Widowed 4 ☐ Divorced		□ № ARMY	_	Specify:	,,	Specify: BL	
21215-0036	72 hours "natural", dical Ex		15. Decedent	t's Education	16a. Dece	dent's Usual Decupati	ion	10	6b. Kind of Business/li	ndustry
215	트 - 로	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	life.	kind of work done du DO NOT use retired)	ring most of workin	ig .		
	illed with Hygiene. other ther	Con	12th			L CARRIER			GOVERNMENT	Γ
Maryland		Be	17. Father's Name (First, Middle, JESSE MOORE	Last)			8. Mother's Name  MATTIE JE		aiden Sumame)	
Ž	should be and Menta is marked sumatic ev	2	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mail				City or Town, State, Z	ip Code)
<u>≅</u>	ath a		VERDELL SIMPKIN		11907	WIMBLETON	N STREET	UPPER MA	ARLBORO, MI	20774
ē,	of Heal item 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place)		ate 20	Oc. Location - City or T	Town, State
E	a		1 ∑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate	CEMETERY	12-10	-2005 J	JACKSONVILI	LE, FL
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee	00	2. Name and Address	of Facility JB	JENKINS	FUNERAL HO	OME
	2011		. K.D. H	aha		74 LANDOVE				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car only one cause on ear	used the death. Do not en th line.	ter the mode of dying,	such as cardiac or	respiratory arres	st,	Approximate fnterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	ACUTE	SEVERE GAST	ROINTESTIN	NAL BLEED	ING		Cristians Boarn
47/	/Medical Examiner		1630 (III GOZ (II)		r as a consequence of): DECOMPENSAT	TED CONCECT	PTWE UEAD	יי האדרוום	) T	
1 1/2		r G	Sequentially list conditions, if any, leading to immediate	b	r as a consequence of):	ED CONGEST	LIVE HEAR	I FALLUR	CE .	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>М</b> НҮРОТ	ENSION					
ó	be executed sicien and burial-transit		resulting in death) Last		r as a consequence of):					
8760,	ate be ex hysicien the burial	licai		d. RESPI	RATORY FAILU	JRE				
9	leath certifica attending ph for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy				23d. Date of deliv	verv
Box.	death a atter d for u	iciar	in the past 12 months?	4 ☐ Pregna	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O.	tt the de by the s tached	hys	9 Unknown	9□ Unknov	m					
	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Ď	Part II. Other significant condition	ons contributing to dea	th but not resulting in the	underlying cause given	in Part f.	1	acco use contribute to 2 □ No 3 □ Pro	the cause of death?
or	w requir been si should	etec						24a. Was an	_	
Records,	The lav	Completed						autopsy performe	ed? prior to c death?	topsy findings available ompletion of cause of
Vital			25. Was case referred to medica				26. Place of Death		No 1 Yes	2 🗌 No
>	Physician: this certifica ral director, p	To Be	examiner? 1 ☐ Yes 2X☐ No	Hospital:	patient 2 ER/Outpatie	Other			ice 6 Other (Spec	ufv)
Joμ			27. Manner of Death	28a. Date of				8d. Describe how		
Sion	Attending r death. sctor: After y the fune	atic	2 Accident investi	gation			es 2 No			
Division	i Dir	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Place c	f Injury - At home, farm, s g, etc. <i>(Specify)</i>	reet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
hood	Hospital		29a. Certifier X Certifyin	ig Physician: To the b	est of my knowledge, dea	th occurred at the time	, date and place, a	nd due to the cau	use(s) and manner as	stated.
	within 24 To the Fu	Medicai	one)	and manne	sis of examination and/or in or stated.					
<b>\</b>	To To Con	-	29b. Signature and title of certific	25/		29c. License :			d. Date signed (Month	
	50		30. me and a dress of person	who co leteringing	of death (Item 23a) (Type	Print)	19	16/0	LUCIA LI	4000
2	(4)		31. Date filed (Month, Day, Year)	F 400	n 1118	Londover	~ Rd	Chever	ecember 2 -ly Md.	20785
	Sta Regist		DEC 0 6 2	005	gistrar's Signature	de			ę.	

Y

Moore Robert

			For Stata Registrar		State		d / Depa		nt of H	ealth and	Mental Hy		0.5	41231
	Physici	an	1. Decedent's Nam			1 7					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (		h McQui			4b. City	Town, or	Location of Dea	DECEMB	ER 3, 2	2005 Inty of Deat	9:12 PM M
	Examin	er *, ^		MEDICAL				T.	A PT.A	TA. MAR	YLAND	C	HARLE	
	Funeral		5. Social Security N 579-20-4		.Sex 1□M 25√F	7. Age (In yrs.	last birthday) 82 Yrs.	If Unde Months	Days	II Under 24 Hrs Hours Min	s. 8. Date of B (Month, D	irth ay, <i>Year)</i> 1, 1923	9. Birt	hplace (State or Foreign buntry)
è	Director	Ř.	Usual Residence o	f Decedent							pept. 15	1923	was	h., DC
	/arylar	ō	10a. State Maryland	10b. County  Char	·loc		y. Town or Lo Waldor							10d. Inside City Limits 1 分 Yes 2 ☐ No
	n the N r 28a-i	Director	10e. Street and Nu	mber			Waldol		o Code			10g. Citizen	of What Co	puntry?
	ath wit	raiD		Meadowbr	ook Lane		0 1:-			2060			USA	
200	fter de r Items ulrer n	Fune	11. Marital Status  1 Never Mari	ried 2 Marrie	Armed F	212 No					Specify Yes or N rto Rican, etc.)	0- 14.	Black, Whit	
1	nours a	d by	3  Widowed		It Yes, G Year or [	IVO		1 🗌 Yes				,		nite
Quiller d 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ne Mcdical Exeminat must be notified.	Completed by Funeral	(Spe		grade completed,		16a. Dece (Give life.	dent's Usu kind of wo DO NOT o	al Occupa ork done d ise retired,	ation furing most of wo )	orking	16b. Kind o	of Business	Industry
312	filed with Hygiene other tha	Com	12th			(1-4or 5+)	Med	dical	Assi	stant		·	vate	
	nit. Pages 1 and 2 should be fifed within 72 hours after death with the Marylan ariment of Heath and Mental Hygiene. ortant: if item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at a.g.	To Be	17. Father's Name Edwa	(First, Middle, La rd Kober							ime (First, Middle ie Dowe]		name)	
Man	12 sho h and 7 is mu		19a. Informant's N		o (Type, Print) agen/Dau	ahter		-			Route Numi esville,		wn, State, 2 0637	Zip Code)
≥ ē.	of Health of Hea		20a. Method of Dis	position		20b. F	Place of Dispo cemetery, crea				Date			Town, State
∑ iii	Pages ment of ant: if it			☑Cremation 3 5 ☐ Other (Spe	□Removal from cify)		ropoli	itan (	Crema	tory 12	-5-05	Alexa	ndria	, Va
Ball	permit. Pag Department Important: any Injury c		21. Signature of F	uneral Service Li	L. M	wton					eall Fur hway Bow			15
	Physician		23a. Part1. Enter shock, or her Immediate Cause disease or conditi	art failure. List oi (Final	omplications that nly one cause on	caused the deat each line.	h. Do not en	ter the mo		g, such as cardia		arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a consec	juence of):	Ovan	2.4	Llebon	tone.	<b>-</b> 24		
		Jer	Sequentially list or if any, leading to a cause. Enter Und Cause (Disease of that initiated eventials)	onditions, mmediate	b. — Due to	(or as a conseq	juence of):	agn	anı	Hyper	ctensi	ON		
	be executed sician and burial-transit	Examiner	Cause (Disease of that initiated event resulting in death)	r injury	c	(or as a conseq	manca of):							
760,	ite be ex ysician ne burial	cai E	,		d	(Or as a conseq	puerice or).							
89	ntificating phy		IF FEMALE:		-									
P.O. Box	Attending Physician: The law/requires that the death certificat in death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was deceded in the past 12 1 □ Yes 2 9 □ Unknown	2 months?	1 🗆 Live	utcome of pregnation 2 Feta Inant at time of conown	ıl death 3[	□Ectopic p □ Other (s				23d.	Date of del Month	ivery Day Year
ds, P.	vrequires that the death been signed by the atte should be detached for	by Ph	Part II. Other sign	ificant condition	s contributing to	death but not res	sulting in the u	underlying	cause give	en in Part I.		tobacco use		the cause of death?
200	law requast teen	Completed		par	Kinsu	η					24a. Wa		tb. Were au	itopsy findings available
I Re	The la	Com		Deh	ydrati	on					per	opsy formed? 2 No	death?	completion of cause of 2 No
Vita	ysician: T	Be	25. Was case refe examiner?	/	Hospital:			77.00	Othe	ar.	eath (Check only			
o	g Phys er this eral dii	n; To	1 ☐ Yes 2 €	ith		Inpatient 2 of Injury oth, Day Year)	28b. Time o		OA Injury Work	4 ∐ Nursing	Home 5 Res			cify)
sion	ittending Ph death. ctor: After th / the funeral	catio	1 ☐Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investiga 6 ☐ Could no	tion		Injury	М	1 🗆 '	Yes 2 □ No				
Division of Vital Records,	Mospital or Atteno 24 hours after deat Funeral Director: etely filled in by the	Certification;	4 Homicide	determin	ad 288. Plac	e of Injury - At h ding, etc. (Speci	ome, farm, st fy)	reet, lacto	ry, office		28f. Location City or To	(Street and N. own, State)	umber or Ri	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the caminer: On the and ma	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	th occurred nvestigation	at the time n, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time	e cause(s) and , date and pla	I manner as ce, and due	stated. to the cause(s)
	To the I within 2. To the I	Σ	29b. Signature and	ditte of cention				29	c. License	number			gned (Mont	h, Day, Year)
./	TH		30. Name and add	tress of person w	ho completed car	use of death (Ite)	m 23a) (Tvna	, Print)	D-5	57708		100	1-0	7
V			OMAIS,		·				<b>VALD</b> C	RF. MAR	YLAND 20	0602		
7 9	Sta Regista			nth, Day, Year) C 0 6 20	05 Ke	Registrar's Sign	April 1	L		,	YLAND 20			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1600 P M Dorothy S. McCleary December 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number **Funeral** Days 1 ☐ M 21 ☐ F Hours NOV 10, 1913 Director 190-32-4990 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 10a. State traumatic evant, If a Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Pennsvlvania Chester Lincoln University 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 185 Hess Mill Road 'natural', or Itams 23a 19352 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give <sup>1</sup> Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ğ 3 

Widewed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other trainmeir. Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry W. Strahorn, Sr. Daisy Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. McCleary/Son 213 Cunards Mill Rd., Lincoln University, PA 19352 20b. Place of Disposition (Name of Chemetery, capacity or other place)
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State ⁴ 4 □ Donation 5 □ Other (Specify) 17, 2005 Cherry Hill, Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia week. Prosician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by the attending physician The law requires that the death certificate be by Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autop performe 21 1 Tyes ospital or Attanding Physician: Thours after death.
unaral Diractor: After this certificate if filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Surring Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WELL E. LATTIN 101 LOLONIA WD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

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			For State	State of Ma	ıryıanı	d / Departm			a ivier		1	005	1.1226
			Registrar			Certific	ate of	Deam			Reg. Ne.	000	41630
A	Physici	an	Decedent's Name (First, Middle, Lass	2	1 1	11 -1				Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Gabriella	Lynn	101	otter				Decer		7,200	
	Examin	er	4a. Facility Name (If not institution, give			4b. (		or Location of D	eath			County of Dea	
	1 40	42	Memorial					ston	I to a To			Talbot	
	Funeral		Social Security Number     6. S	9X 7. Age ☐ M 2 120 F	e (In yrs. i	Yrs. If U			Min.	Date of Bir (Month, Da	ax, Year)	9. Bir	thplace (State or Foreign ountry)
- Pr	Director			70		113.		1 0	00	12/7	105		MD
and	*	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Location							10d. Inside City Limits
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with the Maryland	r 28a-f show	Director	Maryland Carolin  10e, Street and Number	e	D	enton 101	. Zip Code				10a. Citiz	en of What Co	ountry?
with		ā	1201 Tuckahoe Cou	rt			21629			i			es of Americ
death	ns 23	Funerai	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. Was D	ecedent of	Hispanic Origin	? (Specify	Yes or No		4. Race - Am	
ler	등 를	Fun	1 Never Married 25 Married	Armed Forces? 1 ☐ Yes 2 ☑	10	If Yes,	specify Cub	an, Mexican, P	uerto Rica	an, etc.)		Black, Whi	te, etc.
036 urs a	0	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 L Ye	s 21X No	Specify:				Specify:	asian
1215-0036 within 72 hours after	natural', Jisal Ex	ted	15. Decedent's Ed	lucation		16a. Decedent's	Usual Occu	pation	fantema		16b. Kir	nd of Business	
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21215-0036 d within 72 hours af	a dien	Completed	Zidinan, Colonia, (Colonia, Colonia, Co		,	N	I/A					N/A	
	other vent,	Be C	17. Father's Name (First, Middle, Last)				•	18. Mother's	Name (F	îrst, Middle	, Maiden	Sumame)	
<b>a</b> g	Mental arked o	70 E	Kenneth	Jay Motter	•			Coll	een i	Marie	Gate	es	
Maryland 10 2 should be file	EEE		19a. Informant's Name/Relationship (	Гурө, Print)		19b. Mailing Add	ress (Stree	t and Number o	or Rural R	oute Numb	er, City or	Town, State,	Zip Code)
	Health tem 27 I		Kenneth J. Motter	Father	•	1201 Tuc	ckahoe	Court,	Den	ton,	Mary.	land 2	1629
– עם כ	of He roth		20a. Method of Disposition	Domoual from State	20b. P	lace of Disposition emetery, crematory	(Name of or other pla		Date			cation - City or	
mor Pages	int: If		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Gre	ensboro (	Cemete	ry   12	2/9/2	005	Gree	nsboro,	Maryland
datin altin	Department Important: I any injury o	1	21. Signature of Funeral Service Licer	59 h		22. Nam	e and Addr	ess of Facility	-ma	ת כד			
<b>a</b>	8 5 8		Kandy	(1 (cde		12.3	e run South	eral Ho Second	Stre	et. I	ento	n. Mary	land 21629
E.	As		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death							, .	Approximate Interval Between
ΡI	hysician		Immediate Cause (Final disease or condition	ELL		-~							Onset and Death
	Medical		resulting in death)	a. Due to (or as	a conseq	uence of):	7.19						
E:	xaminer	8	0 - 1 N P A PP	, Cerv	ical	lincen	opkno	•					
H.	E. C.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):							
cuted	and I-transi	Examiner	that initiated events	C									
<b>60,</b> be execut	icien and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):							
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9	igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE:										
Box	tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth			ic pregnanc	У			2	3d. Date of de Month	livery Day Year
. Е	ne at	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of d	eath 5 Othe	r (specify) _		<u> </u>			WOTH	Day Tour
P.O.	by t	Phy	9 🗆 Unknown							00 - Did	A - b		a the server of death?
<u>8</u>	bed bed		Part II. Other significant conditions of	onthouting to death b	ut not res	uiting in the underly	ing cause g	ven in Part I.					o the cause of death?
ord	s uees	Completed		-							Yes 2		
e C	as be	pie								24a. Was	DSV	24b. Were a prior to	utopsy findings available completion of cause of
<b>A</b> 5	ate h page	оп								perf	ormed?	death?	s 2 No
ita	etor.	Be (	25. Was case referred to medical examiner?					26. Place of	f Death (C	Check only	опе)		
<b>&gt;</b>	dire	2	1 ☐ Yes 2 ♣No	Hospital: 1 🖄 Inpatie	ent 2 🗆	ER/Outpatient 3[	J DOA		ing Home	5 🗌 Res	idence 6	Other (Spe	ecify)
0 0	fter t	ä	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Inji			1. Describe	how injur	y occurred	
Division of Vital Records,	eath. or: A the fu	Certification: To	2 Accident investigatio	0		М		Yes 2 No					
Ϋ́	ter d irect irect	ŧ	3 Suicide 6 Could not be determined		ury - At hi c. <i>(Specif</i>	ome, farm, street, fa fy)	ctory, office	•	28f		(Street an own, State		Rural Route Number,
Division of Vital Records, P.O. Box 68	within 24 hours after death.  To the Funerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should												
dsop	Fune ely fi	Medical	(Check only 2 Medical Exal	i <b>ysician</b> : To the best <b>niner:</b> On the basis o	f examina								
ar a	the I	Jed	one)	and manner st	ated.		200 Ligar	ise number			:Od Dat	e signed (Mor	oth Day Vear
P	T v	-	29b. Signature and title of certifier	16.		. ~						12/8/	
			July 1	BUNA		MO	D24	617	_			1901	
			30. Name and address of person who										
ys.	5 50		Philip R. Bowman 31. Date filed (Month, Day, Year)	M.D. 522	Cynt	wood Driv	e, Eas	ston, Ma	aryla	and 2	1601		
	St. Regist	ate rar	DEC 8 8 2005	A Ragio	M. J. Olyma	Ann M.							

				For State Registrar	rieas	State		land / De		of Hea	Ith and M	lental Hy		) 0 5	41237
_		Physici /Medic		Decedent's Name (	First, Middle,	-		171	LLER			2. Date of De Month	Day	2005	3. Time of Death 9-27 A M
	*	Examir	er	4a. Facility Name (If n						own, or Loc	ation of Death ir			unty of Deat	
٠.	1.4	Funeral Director		5. Social Security Nur 216-38-298		.Sex 1 <b>1</b> 27 M 2□ F	7. Age (In	yrs. last birthda Yrs.	Months		Under 24 Hrs. ours Min.	8. Date of Bir Month, Da 3/15/19	th		hplace (State or Foreign unitor) Virginia
		D.		Usual Residence of D				. City, Town or	Location			7/10/10			10d. Inside City Limits
		death with the Maryland ma 23a or 28e-f ehow r mast be matified at	tor	MD		ford	100		lingto	n					1 ☐ Yes 2X No
 Q		with the	Funeral Director	10e. Street and Numb					10f. Zip (				-	of What Co	untry?
9		ma 23	erai	1616 Poole	ROAG	12. Was De	cedent Ever	in U.S. 1	210: 3. Was Decede		nic Origin? (Spe	ecify Yes or No Rican, etc.)	US. 14.	Race - Ame	
D	5-0036	72 hours after death with the Marylan 'natural', or itema 23a or 28e-f ehow olcal Expirier mast be notified at	by	1 ☐ Never Married 3 ☐ Widowed 4		Armed F	Forces? 2 No Sive Dates: 196		If Yes, specif		lexican, Puerto pecify:	Rican, etc.)		Black, White ecity: Wh	
3/13/05	15-0	in 72 ho n "natur	Completed	(Specify		grade completed		16a. De (Gi	cedent's Usual ive kind of work b. DO NOT use	Occupation done during retired)	g most of work	ing		of Business/	
$\bar{c}$	212	filed within I Hygiene. other than "rent, the Much	Com	Elementary/Second			(1-4or 5+)	Aut	o Work			(F)		motive	2
6	land	should be fi bd Mental H marked ot imatic ever	To Be	17. Father's Name (Father's Name (Fa								e (First, Middle) e Goins		mame)	
-	Mary	nd 2 shith and 27 is m		19a. Informant's Nam Stella Ma								al Route Number ngton,		own, State, 2 1034	Zip Code)
	Baltimore,	Pages 1 al ment of Hes ant: if item ury or othe		20a. Method of Dispo t XBurial 2 1 4 Donation 5	Cremation 3		Cinto	ob. Place of Dis cemetery, c el Air M	rematory or oth	ier place)		Date <b>/2005</b>	20c. Locat Bel A	ion-City or ir, MD	
	Balt	permit. Pages Department of Important: If I any injury or once.		21. Signature of Fund	4.8.1	weeled	e e			uneral	Home, Inc			Delta,	PA 17314
_		Physician		Immediate Cause (Fi	failure. List or	nly one cause on	each line.				ich as cardiac o		rrest,		Approximate Interval Between Onset and Death
J.		/Medical Examiner		disease or condition resulting in death)	- (	a	OTE (or as a cor	nsequence of):	0/10/10/10		77766 77				72 HOURS
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re F	Box.	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent as in the past 12 m 1 Yes 2 9 Unknown	onths?		birth 2 .	Fetel death	3 □Ectopic pre 5 □ Other (spe				23d	. Date of deli Month	ivery Day Year
robe	s, P.O	es that tigned by	ρ	Part II. Other signific						use given in	Part I.				the cause of death?
G	cord	w requii	Completed			BSTRU				V Di	SEASE	24a. Was			obably 4 Unknown topsy findings available
-	I Re	The ete h page	Comp	Ciritor						/	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	autor		prior to death?	completion of cause of 2 No
iller	Vita	Physician: r this certific ral director,	Be	25. Was case referre examiner?	/	Hospital:		2 ER/Outpat		7		Check only			
7.5	n of	ding Phys	on: To	27. Manner of Death	5 ☐ Pending	28a. Date		28b. Time		c. Injury at Work?		me 5□ Residente l			ory)
5	Division	or Attending ter death. Ilrector: After n by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	investiga 6  Could no determin	t be 28e. Place	e of Injury -	At home, farm, pecify)	M street, factory,	1  Yes		28f. Location ( City or Tox		umber or Ru	iral Route Number,
		To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce	29a. Certifier 1 (Check only 2 one)	Certifying	Physician: To the	ne best of my basis of exar nner stated.	knowledge, de mination and/or	eath occurred a	t the time, d n my opinio	ate and place, n, death occurr	and due to the red at the time,	cause(s) and date and pla	d manner as	stated. to the cause(s)
		To the within To the comple	Me	29b. Signature and tit	le of certifier	0.0	ъ.			License nur	mber 1207			igned (Manth	
		Do		30. Name and addres						OCRES	T COOR	r, BAL	TIMORE	5 , M.	D 21286
		Sta Registr		31. Date filed (Month)	Day, Year)	32.	Registrar's S	Signature	- /	-4		*			
	DH	MH 17 Rev 1/2			JECI 9	2005	Laine .	K	poel						
								ORIG	INAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 12-6-05 Registrar Amend#2. Per Phys & #20a. Per FH PCC Certificate of Death 2. Date of Death]0-24-05 1. Decedent's Name (First, Middle, Last) Physician 6:35 AM Njoch 2005 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Bultimore Bayesen Medical Corter Johns Hopkins If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1MM 2□F Cameroon 30 063 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show the Medical Examiner must be notified at 1 Pres 2 No Silver Spring Director Mortgomeru Maryland 1 10e. Street and Number 10g Citizen of What Country? 'natural', or Itams 23a Stree amercon 13010 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 PNo If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes Specify Specify: Black 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. m 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mfare lorence 15 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13010 Flack St. Silver Spring MD. permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is
any injury or other trau MD. 20906 13010 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 X Burial 2 ☐ Cremation Dec. 3, 2005 4 ☐ Donation 5 ☐ Other (Specify) 01 Funeral Homes 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Md 20904 11315 Lockwed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 8 None 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate 1X Yes 2 No or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 3 No Hospital: 70 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \( \text{Homicide} To the Hospital Certifying Physician. To the best of my knowledge, deam occurred at the time, date and place, and due to the date (c) and manner its stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

istrar DEC 0 6 2005

30. Name and address of person

31. Date filed (Mon Day, Year)

Watkin

7940 Eastern 32. Registrar's Signature

mpleted cause of death (Item 23a) (Type, Print)

		•	1 = State Degistrar	State of Ma	aryland /		artment of Herificate of L		Mental Hyg	iene	6 41239
15	* * *		Decedent's Name (First, Middle, Last)	)					2. Date of Deat Month	h	3. Time of Death
	Physicia Medic/			Helen R.	. Norri	s			Decembe	r 13, 20	05 8:31 P M
1	Examin	4	4a. Facility Name (If not institution, give				4b. City, Town, or		th	4c. County of E	
			Anne Arundel Medic  5. Social Security Number 6. Sec		e (In yrs. last b	nirthda vì	Annapo	L1S If Under 24 Hr	S. R Date of Birth	Anne A	rundel  Birthplace (State or Foreign
	Funeral Director			1 M 2 STE	39	Yrs.	Months Days	Hours Min		Year)	Country) ashington, DC
	D.		Usual Residence of Decedent								
	arylar show	_	10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the M	ecto	Maryland Anne Aru	ındel			Crownsv 10f. Zip Code	ille	1	0g. Citizen of Wha	
	with 3a or	ΙDΙ	1361 Morgans Ridge	Lane			21032			USA	. Country.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tes 2 X If Yes, Give Year or Dates:			Was Decedent of His f Yes, specify Cubar		Specify Yes or No- rto Rican, etc.)		American Indian, Vhite, etc. White
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16	a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired;	ition uring most of we	orking	16b. Kind of Busin	ess/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use retired; e Worker			Retail	
D 5	e filed within al Hygiene. I other than '	e Co	9th 17. Father's Name (First, Middle, Last)			TTTC	e MOLVET	18. Mother's Na	me (First, Middle, I		
au	should be nd Mental marked o	To B	George Ch	aloupe				Za	riv	Suttle	
Maryland	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (T)	rpe, Print)	19	9b. Mailir	ng Address (Street a	nd Number or F	lural Route Number	, City or Town, Sta	te, Zip Code)
_	7 5 E E		Dolly H. Iredell/	Daughter	<del></del>		Martingh	am Dr.,	St. Mich		
Baltimore,	m O		20a. Method of Disposition  1   ☐ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		cemei	tery, crer vood	cemetery	12–1	6–05	20c. Location - City Washingt	on, D.C.
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Furteral Service Licens	-			973 Solom	ons Isl	and Rd. E	dgewater	neral Home , MD 21037
-(46	€ <sub>0</sub> *		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused ne cause on each i	d the death. Dene.	o not ent	er the mode of dying	g, such as cardia	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
ĵ.	Physician		Immediate Cause (Final disease or condition resulting in death)	aK	esper a	2 +8	my fa	elur	2		Offset and Death
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2	T = 0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):	7. 1	10.		,	
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.O. Box	that the death certificate ed by the attending phys detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Js, P	8 6 9	by	Part II. Other significant conditions co	ntributing to death b	out not resulting	g in the u	nderlying cause give	on in Part I.	23e. Did tol		te to the cause of death?
Sor	w requir been si should	etec	Diseesen vale	essels					24a. Was a		e autopsy findings available
Vital Records,	The lav	Completed	Huston The	and a	releid	1.00			autops	y prior negl? deat	to completion of cause of
Ital		BeC	25. Was case referred to medical	ian p	geson	Cork		26. Place of De	1 ☐ Yes eath (Check only on		Tes 2 No
of <	d is	ToE	examiner? 1 ☐ Yes 2 X No	Hospital:		Outpatier	nt 3□ DOA Othe	or: 4 🗆 Nursing	Home 5 ☐ Reside	ence 6 Other (	Specify)
ou o	ing After	tion:	27. Manner of Death    Natural 5   Pending 2   Accident   investigation	28a. Date of Inju (Month, Da	ury 28b	n. Time of Injury	Work	at :? ∕es 2 □ No	28d. Describe ho	ow injury occurred	
Division	il or Attanding after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, tc. (Specify)	farm, str	eet, factory, office		28f. Location (St City or Town		r Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C			of examination				ce, and due to the courred at the time, d		
	To the within 2 To the comple	×	29b. Signature and title of certifier	Joseph	Herson	X	29c. License	number	71	9d. Date signed (N	·
	6		30. Name and address of person who c	ompleted cause of	death (Item 33	a) (Type,	Print) Judy	H. Jos	seph-Herbe		
A.	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signature	71	harles	010 ,00	v., ×19	0	
4	Registi	0 1 0 200E									

05-08447 LEIGH T PACE Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Items: 23a part 1,27,28a,6,c,d,e,f per MEO G-851 1/21/06 reb State of Maryland / Department of Health and Mental Hygiene WHM Unpend Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 14, 2005 **Physician** 1:30 P M Leigh Todd Pace /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK
If Under 1 Year | If Under 24 Hrs. FREDERICK CO 606 E. PATRICK STREET 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Yrs Director Germany 523-57-5881 34 3 - 7 - 1971Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r then "naturel", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1√Yes 2 No Director MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 65 Sherwood Drive 21 7 9 3

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates Peace 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: δ 3 ☐ Widowed 4 Ĭ Divorced Τ'n White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintanence Concrete Manufacture ind Mental Hygie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be William T. Pace Janice P Hodgson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Heelth if 65 Sherwood Drive Walkersville, MD 21793 Father William T. Pace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12/17/2005 Smithsburg, MD 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service I lan 106 East Church Street, Frederick MD 21701 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Imm Hatt Cause (Final Carbamazepine Intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner inding physicien end use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of defivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 Д Yes 2 □ No 24a. Was an page 2 s autopsy performed? 1X Yes 2 No Attending Physicien: After this certifice funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one) XYes 2 No Other 4 Nursing Home 5 Residence and Other (Specify) SCENE Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury! n 28b. Time of Ind 28c. Injury at Work?

12/14/05 1.20 p M 1 □ Yes 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 XNo investigation 2 Accident 12/14/05 1:20 P. Subject Ingested Drug the Director: 3 X Suicide 4 ☐ Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 606 E. Patrick St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funerei Direct completely filled in by 5 Found at Residence apt.5 Frederick, Md. fo the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCME DECEMBER 15, 2005 mio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 PENN STREET, BALTIMORE, MARYLAND, 21201 LING MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1

2005

			For State Registrar	State of M	-	partment of F ertificate of		d Mental Hygid	ene . No 2005	41241
	Physicia		Decedent's Name (First, Middle, Frances	<sub>Last)</sub> Jan	et	Paignon		2. Date of Death December 5	Day OO5 Year	3. Time of Death 2:35 P M
	/Medic Examin		4a. Facility Name (If not institution, 6207 Joyce Drive	give street and number	7)	4b. City, Town, o	or Location of De		4c. County of Dea Prince G	
Ī	Funeral Director		5. Social Security Number (550–26–3822)	3. Sex 7. A 1 ☐ M 2 ဩ F	ge (In yrs. last birthd 91 Yrs	Months Davs	If Under 24 H Hours M	in. 8. Date of Birth (Month, Day, ) November 12	rear) C	thplace (State or Foreign buntry) Sachusetts
	ryland ihow		Usual Residence of Decedent  10a. State 10b. County	•	10c. City, Town or		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	r 28e-f s	recto	Maryland Prince G	eorge's	Temple	10f. Zip Code		100	g. Citizen of What C	1 ☐ Yes 2412 No ountry?
	th with	al D	6207 Joyce Drive			20	748		USA	
036	should be filed within 72 hours atter death with the Maryland of Mental Hygiene. marked other than "netural", or Items 23a or 28e-f show imatic avant, it a Madical Examinar must be indiffied at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1 □ Yes 2  If Yes, Give Year or Dates	Mo	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√2 No		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
Maryland 21215-0036	within 72 ho ene. than "netur ne Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12th		(G	cedent's Usual Occup ive kind of work done a. DO NOT use retire Secretary	during most of v	vorking	Sb. Kind of Business Federal Gove	
and 2	a la	Be	17. Father's Name (First, Middle, L Emile E. Paignon	ast)	· · · · · · · · · · · · · · · · · · ·	screeny		Name (First, Middle, Ma		ET (III) ET (
ary	2 should and Men is marka eumatic	၉	19a. Informant's Name/Relationship	р (Туре, Print)	19b. M	ailing Address (Street		Rural Route Number, (	City or Town, State,	Zip Code)
	7.2 mg		Fay Hutchinson / Gu	ardian	4107	Buck Creek	Road Tempi	le Hills, Mr		18
Jore	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		e cemetery, o	sposition (Name of rematory or other pla		3,	c. Location - City or	
saltimore,	permit. Pages Department of Importent: If i any injury or o		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service)		Kalas Cr		r === 141+	13, 2005 Ed eorge P. Kala Oxon Hill, Ma		
m E	205 20		23a. Part1. Enter the disease, or o	omplications that cause	ed the death. Do not					Approximate
	Pnysician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each a CHRONIC	line. C OBSTRUCTIVI					Interval Between Onset and Death
	Examiner		One wastingthe line and distance	b.	s a consequence of):					
	pe tis	iner	Sequentially list conditions, in any local immediate cause. Enter Underlying Cause (Disease or injury		s a consequence of :					
, V	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):					
8760,	ate be ohysicia the bur	dlcal	1	d						
O. Box 6	The law requires that the death certiticate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of de Month	livery Day Year
ds, P.	w requires that been signed by should be deta	by	Part II. Other significant condition	ns contributing to death	but not resulting in th	e underlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
Vital Records,		Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
/ita	cian: sertitic ector.	Be	25. Was case referred to medical examiner?	Hospital:		C+		Death (Check only one)		
	Physical this carral direction	.: To	1XXYes 2 ☐ No 27. Manner of Death	1 Inpa 28a. Date of In (Month, D	tient 2 ER/Outpa	IIBIIL 3 DOA		g Home 5XXResiden 28d. Describe how		city)
on	Attanding Physician: or death. actor: After this certifically the funeral director.	atlor	1XXNatural 5 ☐ Pending 2 ☐ Accident investiga		Jay Year) Inju		rk?  Yes 2∐No		. ,	
Division of	pital or Attano ours after deatl iaral Diractor: tilled in by the	Certification:	3 Suicide 6 Could no determine	and 28e. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	Hos Hos Pur ely	ledical (			of examination and/o			ace, and due to the cau courred at the time, date		
į	To tha within 2 To tha complet	W	29b. Signature and title of certifier	FRO	le MS	29c. Licens	se number	1	Date signed (Montecember 13,	
	5		30. Name and address of person w		death (Item 23a) (Typerbend Road	pe, Print)				
	Sta		31. Date filed (Month, Day, Year)	32. Paris	strar's Signature		on renyl	and 27//44	· ····	
	Registi	ar	DEC 2 1	2005	EUR St.	Sperke				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ReguNo.U 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month PIERCE DICEMBER EDWAVO ISSAL 2005 20017 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday) HAVILED & GIACE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birl IF ALFOND HARFOND MEMORIAL 8. Date of Birth (Month, Day, Year) Sept. 26,1933 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1⊠M 2□F Months Days Hours Min Yrs. Maryland 213-30-5348 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Port Deposit Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 180 Funk Road 21904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1∑Yes 2 □ No If Yes, Give Year or Dates: 1953 - 55 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Perry Point, Maryland Nursing Assistant Seven Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isaac Edward Pierce Stella Mae McCall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Dennison (Daughter) 320 South Adams Street, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/7/05 West Nottingham Cemetery Colora, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. m. talleran, or Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HASCUD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. [NFAZLTION 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1⊟ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 Ia marked oth any injury or other traumatic avant ones.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Itams 23a or 28a-f show the Medical Examinat must be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

Directo

Funeral

þ

Completed

Be

Physician/Medical þ Compl 2 Certification:

attending physician and for use as the burial-transit Records, Vital After or Attanding death. within 24 hours after or To the Funaral Direct completely filled in by

94 IVA

State Registrar

5 Pending investigation

6 Could not be

determined

1 Yes 2 No

27. Manner of Death

1 🗷 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certified

M-D.

28b. Time of

Hospital: 1 ☐ Inpatient 2 ➤ ER/Outpatient 3 ☐ DOA

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

29c. License number D21809

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YORK ROAD T PRABHUM. D 2336 MUINOMI 31. Date filed (Month, Day, Year)
DEC 0 6 2005 32. Registrar's Signature

peuns

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State	of Maryland / Depa Cert	rtment of Health tificate of Deat	b	giene Reg. No. 0	5 41243
	Physician /Medical	Decedent's Name (First, Middle, Last)  EVA K PECKNAY			2. Dete of De Month DECEMBE	Dey	Year 05 1:00 Pm
	Examiner	4e Fecility Neme (If not institution, give street and n			Town, or Location of Death		
	Funeral	LAYHILL GENESIS ELDERCA  5. Social Security Number  6. Sex	7. Age (In yrs. last birthday)		ER SPRING er 24 Hrs. 8. Date of Birl (Month, De 12/18/1	h y, Year)	9. Birthplece (State or Foreign Country)
	Director	Usuel Residence of Decedent	91 Yrs.		12/18/1	913	PÖLAND
	yland	10a. State 10b. County	10c. City, Town or Loc		. •		10d. Inside City Limits
	vith the Mar or 286-1 or be nortified Director	MD MONTGOMERY		BETHESD			A Yes 2 No
	with the Dec 2 Liberal Liberal	10e. Street end Number 10250 WESTLAKE DRIVE #8	R18	10f. Zip Code 2081		10g. Citizen of W	U.S.A.
036	within 72 hours efter death with the Maryland ene. than "naturel", or items 23s or 28s-f show he Medical Examiner must be noritied at empleted by Funeral Director	11. Marital Status 12. Was De Armed	pecedent Ever in U,S. If Society If Society If Society If Society If Society If Society In Its Inc. In Its Inc. In Its Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.		Origin? (Specify Yes or No can, Puerto Rican, etc.)		e - American Indian, k, White, etc.
Maryland 21215-0036	ed within 72 ho ygiene. ner than "nature it, the Medical I	15. Decedent's Education (Specify only highest grede completed Elementary/Secondary (0-12)  College	(Give k life. D	ent's Usual Occupation ind of work done during mi O NOT use retired) LESPERSON	ost of working	16b. Kind of Bu	siness/Industry
2 pد	tal Hygie d other event, u	17. Father's Neme (First, Middle, Last)	J JA		ther's Name (First, Middle,		
ylar	should be nd Mental marked c umaric ev	MORRIS KULICK			EDA SUTZGAAF		
Mar	s 1 and 2 should be filed within if Health end Mental Hygiene. Item 27 is marked other than other treumatic event, the Mental To Be Compl	19a. Informant's Name/Relationship (Type, Print) BARBARA PECKNAY/DAUGHTE			703, EASTON		
Baltimore,	and	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal fror 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place)	Date ONS 12/05/200		City or Town, State CHURCH, VA
Balti	Departm Departm Importar any Injur	2 Signature of Meral Servic Licensee	ED		UNERAL DIREC		C. ARYLAND 20852
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	t caused the death. Do not entended each line.  INAL AORTIC AN  Due to (or es e consequ	EURYSM	as cardiac or respiratory ai	rest,	Approximate Interval Between Onset end Death
Ć,	ficete be executed in the physician and set the buriel-transit and calcal Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or es e consequ	ence of):			
x 68760,	entificate be ding physicle se es the bur Medical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequ	ence of):			
Вох	the death cent y the attendin ached for use hysiclan/N	Part II. Other significant conditions contributing to	double but not reculting in the un	derbina cauca civan in Par	el 23h Did	ohacco use con	tribute to the cause of death?
P.O.	that the died by the detached	HYPERTENSION	death but not resulting in the dis	denying cause given in Fer	_		3 Probably 4 Unknown
Division of Vital Records,	been sign should be	COPD/ASTHMA			24a. Was perlo	an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	The I	PNEUMONIA			101	se 2X No	1 ☐ Yes 2 ☐ No
Vita	Physician: r this certific and director, T. To Be	25. Was case referred to medical examiner?		Other:	ice of Death (Check only o		
on of	ding Physic h. After this co funeral dire tion: To	27. Menner of Death 28a. Dat	□ Inpatient 2 □ ER/Outpatient te of Injury onth, Day Year)  28b. Time of Injury	3 □ DOA □ 4 1 □ 1 28c. Injury at Work?  M 1 □ Yes 2 [		iow injury occurre	1
Divisi	To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Could not be 28e. Ple	ce of Injury - At home, farm, stre Iding, etc. (Specify)	et, factory, office	28f. Location (S City or Tov		er or Rural Route Number,
	he Hospital in 24 hours e he Funerel E pletely filled edical Ce	(Check only 2 Medical Examiner: On the	ne best of my knowledge, deeth basis of examination end/or inve anner stated.	occurred at the time, date of estigation, in my opinion, do	end place, and due to the eath occurred et the time,	ceuse(s) and mar date and place, a	nner es stated. Ind due to the cause(s)
	within 2 To the comple	29b. Signature and title of certifier	. /	29c. License numbe		29d. Date signed	(Month, Dey, Year)
)	10	· sprouse /	Meno		5691	DECEMB	ER 3, 2005
		30. Neme and eddless of person who completed ca DR. GHOUSIA SULTANA, 12	2107 HERITAGE P	ARK CIRCLE,	SILVER SPRIM	NG, MD 2	0906
	State Registrar		Registrer's Signature	des		-	

DHMH 16 Rev 6/95

Registrar

**ORIGINAL** 

			1- For 12-6-05 State 12-6-05 Registrar Amend#19a.Per I	State of Maryland		artmen <i>tificat</i>			nd Me		giene Reg. No.	05	412	45
The same	Physici		1. Decedent's Name (First, Middle, Last) <b>Ruby</b> C.	Parr						Date of Dea	er Day,	2ď <b>6</b> 5	3. Time of D 9:30	Death <b>A</b> M
	/Medic Examin		4a. Facility Name (If not institution, give sta Crescent Cities			Riv	Town, or erdal	Location of Le	f Death	-	4c. Coun Princ	ty of Death e Geog		
	Funeral Director		5. Social Security Number 6. Sex 578-26-0702 Usual Residence of Decedent	7. Age (In yrs. I 98	Yrs.	Months	Days	Hours	Min.	(Month, Day larch 4	1907	Chan	lace (State or try) cles Co	•••MD
	he Marylan 28a-f ahow ctiffica at	ector	MD Prince Ge		r. Town or Lo rerdale	2							0d. Inside City 1 🔀 Yes 2	
	h with t	al Dir	10e. Street and Number 4900 East West Hig	hway		10f. Zip	737				10g. Citizen of Unite		,	
036	within 72 hours after death with the Maryland ine. then "natural", or items 23a or 28a-f ahow a Medical Evartime missi ke molified at	by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2√√No If Yes, Give Year or Dates:		Was Deced f Yes, spec		spanic Origi , Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Ra Bl	ace - Americack, White,		
9500-6121	within ene. than "	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)		lent's Usua kind of wor DO NOT us emake	rk done di se retired)	tion uring most (	of working		16b. Kind of I		dustry	
Maryland 2	be filed tal Hyg d other event,	To Be Co	17. Father's Name (First, Middle, Last)  John Contee		Home	make				Domestic me (First, Middle, Maiden Sumame) Lyles				
	s 1 and 2 should of Health and Men item 27 is marke other traumatic.		19a. Informant's Name/Relationship (Type)  Diane Ellis (Gran Diane L. Willis  20a. Method of Disposition			0glet	thorp			710 н	yattsv:	ille,	MD 207	81
Bartimore,	Page ment c ant: If ury or		1 ☐ Qurial 2 ☐ Cremation 3 ☐ Rei '4 ☐ Donation 5 ☐ Other (Specify)	moval from State For	emetery, cren t Linc	oln (	ther place Cemet	ery 1	12/10	/2005	Brenty	wood,	MD	
g	permit. Departimport. Import. any inj.		21. Signature of Funeral Service Licenses  22. Name and Address of Facility Fort L  3401 Bladensburg Road											
	Physician / /Medical Examiner		23a. Ran. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  b.	Acute Car  Due to (or as a consequ	diovas uence of):					espiratory an	rest,		Approximate Interval Betwe Onset and De	
8/60,	death certificate be executed e attending physician and nd tor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequ										
O. Box 6	death certifing eathending of	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 [	Ectopic pro						ate of delive onth	ry Day Ye	ar
ras, P.	iw requires that the s been signed by thi should be detache	by	Part II. Other significant conditions control Atheroscleratic Va	-	-	nderlying ca	ause giver	n in Part I.			bacco use cor			
VIтаі жесого	The law ate has b page 2 st	Completed	Dementia, Hyperten	usion						24a. Was a autopo perfor	sy	Were autop prior to con death? 1 \( \subseteq \text{Yes} \)	osy findings av apletion of cau 2 No	ailable se of
	Physician: The this certificate ral director, pag	То Ве	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1   Inpatient 2   E	=B/Outpatien	t 3 🗆 DO	Othor	~		Check only or	ne) ence 6 🗆 Ot	har (Sagaih	1	
ion or	ding h. Atter tune	ertification; T	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work?	at	28		ow injury occu		/	
DIVISION	lospital or Atten I hours after deat uneral Director: sly filled in by the	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify						City or Tow				τ,
	Hos Hur Hur Hur	edical	29a. Certifier Check only one)	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death ion and/or inv	estigation,	at the time in my opi	e, date and nion, death	place, and occurred	d due to the c at the time, c	ause(s) and m late and place,	anner as sta and due to	ated. the cause(s)	
ı	To the within 2 To the complet	Σ	29b. Signature and Infle of certifier	7			. License			2	29d. Date signe		Day, Year)	
0	(7)		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, I		D482	13			12/06	/ 2005		
	Sta	te	Dr. Neelam Ashai 31. Date filed (Month, Day, Year)	4410 32. Registrar's Signat	74th A	ve. L	ando	ver H	ills,	MD 20	784			
	Registr		DEC 0 6 2005	32. Registrar's Signat	Span									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23b, 28a-f, per me 9854, 4-12-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death December 1 Year **Physician** Sally Ruth 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner ever5 rince 6 carge 5 HOSPI rince 6 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) May 22, 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1□M **X**□F Öhio 67 Director 272-34-2597 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Itams 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Charles Waldorf MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 USA 4608 Goldeneve Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coast Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Guard Administrative Assit. Dept. 12 should be filed w and Mental Hygier 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If them 27 is marked of any injury or other treumatic ever Ruth Daughtery John Toxie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Seattle Slew Ct.Waxhaw, NC Greg Phillips/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols 12/7/05 Charlotte Hall, MD 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Benzo diarepines **Physician** Complications /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any larger underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of The law requires that the death certificate be executed burial-transit attending physician and CATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 40 Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ erol 2405°C 1 Yes 2 No 3 Probably 4 diknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? ENCESRO TNOXIC 1 ☐ Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examino? 1⊕ res 2 □ No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No Subject took drugs Nov.1, 2005 unknown after death Director: 2 Accident 6. Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

at home 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 4608 Goldeneye Place within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DEC 0 7 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Month **Physician** 9:06 P M Taylor Pohlman 23, 2005 Edna November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5405 Hesperus Drive Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 F Yrs. 89 20, 1916 Director Texas 458-10-2719 Nov. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, it a Medical Exercit extrast ke rediffied at 1 ☐ Yes 2 X No Funeral Directo Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5405 Hesperus Drive 21044 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fi ment of Health and Mental H tent: If item 27 Is marked ot Benjamin Ear1 Taylor Elizabeth Olive 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ben Olive Morrison/daughter 5405 Hesperus Drive, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Washington Uni.
Medical Center November 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department o Importent: If 4 X Donation 5 ☐ Other (Specify) injury 23, 2005 Washington, DC 21 Signature of Funeral Service Licen ee 22. Name and Address of Facility Columbia Mortuary Services, Inc. any is M00969 P.O. Box 58007 Washington, DC 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a End Stage Chronic Obstructive Pulmonary Disease Physician 4 years disease or condition resulting in death) /Medical **Examiner** Cerebral Vascular Accident with righted sided weakness 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed <sub>c.</sub>Seizures years use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical d Hypertension with Congestive Heart Failure years IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation, Depression Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Tes 2[XNo director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 XNo 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) the funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide Hospitel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature and title of Sertifier 29d. Date signed (Month, Day, Year) 29c. License number kr D54749 December 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Refisi

Allen Reilly



Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

4 East Rolling Crossroads Suite 307, Baltimore, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** JR. FREDERICK G. POUNITZ 2005 December /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 11, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 New York 5. Social Security Number **Funeral** 1 □M 2 □ F Months Yrs. 103 28 8250 1934 71 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No **Funeral Director** MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 3178 Elmmede Road 21042 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 5XYes 2 □ No If Yes, Give Year or Dates: 1957–59 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. by 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) t of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) Mathmetician National Serurity Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Veronica Sanislo Frederick G. Pollnitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3178 Elmmede Road Ellicott City, MD 21042 Betty W. Pollnitz/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Metro Crematory 12-6-2005 Catonsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Embelism Pulmonay **Physician** /Medical **Examiner** Cardiomyopathy Conger tive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 212 No 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred 1. Natural 5 Pending death. investigation 2 Accident after deall Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Solam. December 5 2005 3064-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ballmore Mauland 2122" Kannel Sabapalli 201-109 Back Liver Neek 1000 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2005

			State of Manyland / D	epartment of Health and N	-	-
			_ FOr	Certificate of Death	Rag. No	0000 11010
05	Physici	an	Decedent's Name (First, Middle, Last)     ELWYN FRED PRATT		2. Date of Death Month Da	3. Time of Death 3. 2005 10 17 p M
18.00	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		3, 2005 10 11 PM
	Examin	er	SHADY GROVE ADVENTIST HOSPIT.	, and the second		MONTGOMERY
	Funeral		5. Social Security Number 6. Sex, 7. Age (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
ing.	Director		067-20-1639 1 N 2 79  Usual Residence of Decedent	rs.	JUNE 12	1926 NY
	yland		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Ba-fel	ctor		LLSVILLE		1 ☐ Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23s or 28s-f ehow other traumatic event, in Mudical Exporting mark be notified at	Funeral Director	10e. Street and Number 19101 OLD PINE DRIVE	10f. Zip Code 20839	10g. Ci	itizen of What Country? USA
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S.  Amped Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
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	1 and 2 Health and 27 I			101 OLD PINE DR.,		
Baltimore,	Pages 1 nent of H int: if Ite			y, crematory or other place)		ocation · City or Town, State
Itin			4 □ Donation 5 □ Other (Specify) MONOC.  21. Signature of Finite Incompage.	ACY CEMETERY 12/8		ALLSVILLE, MD
Ba	permit. Departi Importi any inj		- Cyl Fell	22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BA	HOME ARNESVILLE	E, MD 20838
	3.		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
460	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	<u>.</u> K		5/150t and 56ati
i di	Examiner		Oue to (br as a consequence of	Colitic		
		ner	Sequentially list conditions,	9 11 1		
	be executed iclan and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or consequ	The Vascular Drs	CC 50	
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68	tificate ng phys as the		0.			
Вох	leath certificate attending phy I for use as the	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
0.	the the	Physician/Med	1 Yes 2 No 9 Unknown  4 Pregnant at time of death 9 Unknown	5 ☐ Other (specify)		
0	igned by be detac	by Pr	Part II. Other significant conditions contributing to death but not resulting in		23e. Did tobacco	use contribute to the cause of death?
Records,	w require been sig should b	ted t	Renal Failure, Coronary Cretery D	isease, Cocompopa	1 ☐ Yes 2	No 3 Probably 4 □Unknown
3ec	has be	Completed	Swendocordial myocordial 1	interestion 1	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital F	ician: The l certificete ha rector, page	e Co	25. Was case referred to medical	26 Place of Dec	1 ☐ Yes 2 No th (Check only one)	0 1 Yes 2 No
Ĭ.	Physician: this certific al director.	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Out	Other	ome 5 Residence	6 ☐Other (Specify)
n of	ing Ph		Artatolal Soli bilding	njury Work?	28d. Describe how inju	ury occurred
Division	death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far	M 1 Yes 2 No	28f. Location (Street a	nd Number or Rural Route Number,
DIV	s after s after ni Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Stat	re)
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Medical	29a. Certifier (Check only Amedical Examinar: On the basis of examination and			
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Attent completely filled in by the funera	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
	F>F0		by follow	35261	De	cember 4,2005
	6		30. Name and address of person who completed cause of death (Item 23a) (		20027	
100	Sta	ate	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	rive any Maryland	20832	
	Regist		31. Date filed (Month, Day, Year)  DEC 0 5 2005  32. Redistrar's Signature	Grane		

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Perc

12/4 Box 34(11) OK

			State of Maryland / [ State Registrar	Department of He Certificate of D		ntal Hygie		1251
	Physicia		1. Decedent's Name (First, Middle, Last)  Roy Randolph Reed, Jr.			Date of Death Month cember	Day Year <b>4. 2005</b>	3. Time of Death  12:40 A M
-	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) Prince George's Hospita1	4b. City, Town, or the Cheverly	ocation of Death		4c. County of Death Prince Geo	_
*	Funeral Director		5. Social Security, Number 579-36-4210 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rthday) If Under 1 Year Months Days Yrs.		Date of Birth (Month, Day, Ye an . 27,	9. Birthol Count 1929 Wash	ace (State or Foreign ry) ington, DC
	show	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow MD Prince George's Adelp				10	od. Inside City Limits
	th the Mi or 28a-f	Directo	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Count	
10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	8503 20th Court  11. Marital Status  1 □ Never Married  12 Marined  12 Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  1 □ Yes 2 ₺ No	207  13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify , Mexican, Puerto Rica		14. Race - America Black, White, e	an Indian, etc.
Maryland 21215-0036	72 hours a 'natural', o	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupat	uring most of working	165	Specify: WIN	ite ustry
2121	ed within /giene. ier than	Be Completed	Elementary/Secondary (0-12)  College (1-4or 5+)	life. DO NOT use retired) Entrepreneur	r		rivate	
/land	uld be fill Mental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last)  Roy Randolph Reed	:	18. Mother's Name <i>(F.</i> Helen Wama	ling		
	nd 2 sho alth and I 27 is ma r traums		19a. Informant's Name/Relationship (Type, Print)  Sarah Reed (wife)	p. Mailing Address <i>(Street ai</i> 3503 20th Cou	nd Number or Rural Re rt Adelph	i, MD 20	ity or Town, State, Zip 0783	Code)
Baltimore,	ages 1 a ant of Hea it: If item y or othe		1 Rurial 2 Cremation 3 Removal from State	of Disposition (Name of ary, crematory or other place Lincoln Cemet			. Location - City or To	wn, State
Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Service Acease	22. Name and Address 3401 Blades	s of FacilityFort	Lincoln	Funeral Ho	
***	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition					Approximate Interval Between Onset and Death
,8760,	The law requires that the death certificate be executed at the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or injury that initiated events resulting in death) Last  Due to (or as a consequence or injury that initiated events resulting in death) Last	of):  Of):  Of):	HLVMX	17/4		
.O. Box 6	that the death certifica ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	r <b>y</b> Day Year
<u>α</u>	w requires that s been signed b s should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in	in the underlying cause give	n in Part I.  NRSA		co use contribute to th	/
al Rec	tician: The law certificate has b rector, page 2 st	Completed	C-OM-Colits			24a. Was an autopsy performed	f? prior to con death?	osy findings available inpletion of cause of
Division of Vital Records,	ng Phys fter this ineral di	on: To Be		Time of lnjury Work	at 28d		e 6 Other (Specify	7)
Divisio	al or Attendi safter death. I Director: A d in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide  investigation 6 Could not be determined  28e. Place of Injury - At home, for building, etc. (Specify)		'es 2 □No 28f.	Location (Stree City or Town, S	t and Number or Rura State)	l Route Number,
	To the Hospital within 24 hours and to the Funeral is completely filled	edical C	29a. Certifier (Check only one)  1 ☐ Ga→itying Physician To the basis of examination at and manner stated.					
)	To th within To th compl	Me	29b. Signature and title of certifier	29c. License	number 4547	29d.	Date signed (Month, I	Pay, Year)
	(10)		30. Name and ad ress of parson to completed cause of death (Item 23a)	(Type, Print)	Ohin	stor.	Advin	LST HUSE
	Sta Regist		31. Date filed (Month, Day, Yaar)  32. Registrar's Signature	hacks		, ,		

				State of M	<b>nt in Black i</b> i aryland / Der			•	•	
		•	1 - For State Registrar		Ce	ertificate of	Death	Reg	. No. 2 0 0 5	6 1252
1	Physici /Medic		1. Decedent's Name (First, Middle, La Ethel M. Sc					2. Date of Death Month Decemb		
	Examir		4a. Facility Name (If not institution, gi				or Location of Death		4c. County of Dea	
	Funeral		Washington Count  5. Social Security Number  6.		e (In yrs. last birthda	Hagers	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		rthplace (State or Foreign ountry)
Ϋ́K,	Director		213-20-3214 Usual Residence of Decedent	1□M 25€F	80 Yrs.	Months Days	Hours Min.	Apr 13,		MD
	how		10a. State 10b. County		10c. City, Town or		211700			10d. Inside City Limits
	8a-f	Director	PA Fult	on	[v]C	cConnells	ourg	10-	03:	1 Yes 2 XNo
	ath with the 23a or 2	rai Dire	10e. Street and Number 589 Stage	Coach Rd.		10f. Zip Code	17233		J. Citizen of What C	SA
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "neturel" or Items 23e or 28e-f ehow myt highty or other traumatic event, the Medical Examiner must be mailtied at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:		3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5-0	72 ho	eted	15. Decedent's E (Specify only highest gi		16a. Dec	cedent's Usual Occup ve kind of work done	pation during most of works id)	ing 16	b. Kind of Business	s/Industry
121	within 2008.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	. DO NOT use retire atron	id)		Glass mfg	,
d 2	filed v Hygie other i	e Co	17. Father's Name (First, Middle, Las	t)	L.76	atton	18. Mother's Name	e (First, Middle, Ma		•
an	Mental Mental rked c	To B	Emmer O. F	isher			Pansy 1	Pauline D	Ounsmore	
Maryland	and N	_	19a. Informant's Name/Relationship			•	and Number or Rura			
	and and marking markin		Kenneth A. Wall	ech sor		3594 Files	r Rd. Gree			
Baltimore,	Pages 1 nent of H ant: If Ita ury or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		cemetery, ci	rematory or other pla	lens Dec		c. Location - City of Chambers	
Balt	permit. Departr imports eny inju		21. Signature of Funeral Service Lice		Tare		ess of Facility Gro ad St. Way			al Home, Inc
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the death. Do not e	enter the mode of dy	ng, such as cardiac o	or respiratory arres	t,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a Ac	ut ack	Chance	Respirat	v-y Fe	115-4	Onset and Death  weeks
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		•	1		
	<i>.</i>	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	CEU	surgan			
٧	be executed ician and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
760,		a		d						
(687	entifica ing ph e as th	Med	IF FEMALE:							
P.O. Box	Attending Physician: The law requires that the death certificate redeath. sctor: After this certificate has been signed by the attending physey the funeral director, page 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ey .		23d. Date of de Month	Day Year
	s that ned by e deta	by Pt	Part II. Other significant conditions	_			ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ıdş	equire en sig ould b	edt	145 AV94	et Dubel	as mell	ins		1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
Records,	The law re te has be age 2 sho	Completed			6007 - 70			24a. Was an autopsy performe	prior to	
ita	ian: rtifica stor. p	Be C	25. Was case referred to medical				26. Place of Death	h (Check only one)		2010
<u>&gt;</u>	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 No		ent 2 ER/Outpat	IGHT SELDON			ce 6 □Other (Sp	ecify)
Division of Vital	nding Path. ath. rr: After t		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate		ury 28b. Time ay Year) Injury	y Wo	nyat ork? ]Yes 2 ☐No	28d. Describe how	injury occurred	
Divis	al or Atte s after de l Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of Ir	jury - At home, farm, tc. <i>(Specify)</i>	street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best aminer: On the basis and manner s	of examination and/or	eath occurred at the tinvestigation, in my	ime, date and place, opinion, death occurr	and due to the cau red at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	within To the	Me	29b. Signature and title of sertifier			29c. Licen	se number	290	I. Date signed (Mon	ith, Day, Year)
			1 Cappellan ) un	2		D3	18764		Dec 14	,2005
	6		30. Name and address of person who		death (Item 23a) (Typ	pe, Print)	11 = 1+.	1	71	2005,
		210	31. Date filed (Month, Day, Year)		rar's Signature	ack Comp-1	1/2 7-10	1 -1	1236-1142	21116
	Sta	ate	pro 9 1	2005	rar's Signature	Monake)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 14, **Physician** 2005 Robert Paul Schmidt 7:00 and /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7904 Longmeadow Drive Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Days Hours Min. Dec. 25, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∑M 2□F Mary land 463-48-0770 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 17 Yes 2 □ No Frederick Director Maryland Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 7904 Longmeadow Drive 12. Was Decedent Ever in U.S. Aggied Forces? 1 XI Yes 2 Agg 1946 If Yes, Give Year or Dates[ay 1950 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Veterinarian U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Robert Wright Schmidt Catherine Dale Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Longmeadow Drive, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Eric Robert Schmidt/Son Method of Disposition | 20b. Place of Disposition (Name of Date Name o 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur A Funeral Service Licensee 22. Keeney and Basford Funeral Home MQ0021 Mulwick 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinson's Disease Physician Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit signed by the attending physician and the detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23h Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 XNo 1 🗆 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Diracto completely filled in by the 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D40307 December 15, 2005 asagus Cuyene D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene B. Casagrande, M.D., 1564 Opossumtown Pike, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year)

32. Registrat's Signature

			1 - State Registrar Cert	tificate of Death	Reg.	No. O O F	1 1 2 2
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	2000	3 Time of Death
	Physici /Medio		Paul Michael Stevens		Decembe	r 14 2005	22:16 M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Washington County Hospital	Hagerstown		Washing	aton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		220-02-3984 1XM 2 F 25 Yrs.	Working Day's Hours Will.	August 1		ryland
	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	-A'			
	aryla show	-					10d. Inside City Limits  1X Yes 2 □ No
	Ba-f	cto	Maryland Washington Hagers				
	death with the Maryland rms 23a or 28a-f show r must be notified at	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath w 23a		112 East Baltimore St.	21740		U.S.A.	
	tems r m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. W	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	cen Indian, etc.
5	or I	by F	If Yes, Give	☐ Yes 2X No Specify:		Specify: Whi	.te
212-0036	n 72 hours after death with the Marylan "natural", or flems 23a or 28a-f show ideal Examinar must be notified at			anta Haval Ossuration	466	Kind of Rusinsonlin	alian d
ပ်		Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation rind of work done during most of worki O NOT use retired)	ng 160	. Kind of Business/Ir	dustry
7	a filed within 72 if Hygiene. Other than "navent, the Medic	Ę	Elementary/Secondary (0-12) College (1-4or 5+)	,			
N	Hygid Hygid Sther		10 17. Father's Name (First, Middle, Last)	unemployed  18. Mother's Name	(First, Middle, Maid	den Sumame)	
yland		Be					
C.	2 should be and Mental Is marked aumatic ev	٦	Albert E. Stevens  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Address (Street and Number or Rura		ger Stever	
<u>8</u>	d 2 should th and Men 7 Is marke traumatic			East Baltimore S			
	f and feath	119				. Location - City or To	
و	ages on of		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State cemetery, crem				
	rtmer rtant rtant			the second secon		mithsburg	
Baitimore,	permit. Pages 'Department of the Important: If ite any injury or of once.		15			Fiery Fur	
i		1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter	331 Eastern Blvd.		scown Mary	Approximate
			shock, or heart failure. List only one gause on each line.	the mode of dying, such as cardiac c	respiratory arrest,		Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)  a	nopathy			
	/Medical Examiner		Due to (or as a consequence of):	(A) 5			
	LAGITIMICI	L	Sequentially list conditions,	cardio vascular	disease		
	ad sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and -tran	Examin	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
Ď,	be ex		but to (or as a consequence of).				
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o n	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?  1	Ectopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year
o.	the de	Physician	1 Yes 2 No 9 Unknown	Other (specify)			
7	w requires that the death cer been signed by the attendir should be detached for use		Part II. Other significant conditions contributing to death but not resulting in the un-	deriving cause given in Part I.	23e. Did tobaco	o use contribute to t	he cause of death?
Ś	signe signe	b		sorying sauce grown are a			pably 4 Dunknown
cords,	requ	etec	Exogenous Obesity				
Ū	alaw nast e 2 s	npie			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u> </u>	The law sate has page 2.	Completed			performed 1 ☐ Yes 2 ☑		2 No
VItal	Phyeician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	hyei this c	은	1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 XER/Outpatient			e 6 □Other (Specif	y)
	<b>5</b> 0 0 0	on:	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time of Injury	Work?	28d. Describe how i	njury occurred	
<u> </u>	eath.	cati	2 Accident investigation	M 1 Yes 2 No			
DIVISION	or Attending ifter death. Diractor: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide	et, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	I Route Number,
	ital c						
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Att completely filled in by the fun	Medical	29a. Certifier (Check only (Check only 2 Medical Exeminer: On the basis of examination and/or invited to the b	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	the the mplet	Jed	and mariner stated.	29c. License number			
	To To	~	29b. Signature and title of certifier			Date signed (Month,	
			John and W. Differ 199	100-1062		20,10,8	705
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	rint)	,	11	
		Ш	30. Name and address of person who completed cause of death (Item 23a) (Type, FE dwg d ) + +O  31. Date filed (Month, Day, Year) 32. Ressuar's Signature	Hagerston	10 1	19,	
	Sta Registi		31. Date filed (Month, Day, Year)  32. Refistuar's Signature	had a			
		-	DEC 2 1 2005   Men & B	The Third			
DH	MH 17 Rev 1/2	001	<i>y</i>			•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16, 2005 **Physician** 2110 PM secember Maria Schroth Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ORICA (U. KLURKSIDE If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 86 Yrs. 245-64-1901 Director 9/1/1919 Germany Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28a-f show the Medical Examiner coust be notified at MD Harford Bel Air 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1326 Saratoga Drive 21014 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Geiger Lederhuber Anna Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Per. Rep.) Arthur LaGrange item 27 l 1326 Saratoga Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 12/21/05 Aberdeen, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Drovascu Physician eve Few weeks resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical as attending a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) the hed 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Division of Vital Records. 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 25 No 24a. Was an page 2: autopsy perform 25 No 1 🗌 Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Mannum eath 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

School

Anna

31. Date filed (Month, Day, Year) 2 Registra

29b. Signature and title of certified

30. Name and address of person

1 2005

マベカト 32. Resident's Signature

completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2005

December

			For State Registrar		State of	Marylan		artmen rtificat			and M		Reg. No 2	105	11256
	Physici	an	Decedent's Name (First, Mid	die, Last)								2. Date of De Month	Day	Yeer	3. Time of Death
	/Medic	al	Paul 4a. Facility Name (If not institut	K.	treet and numb		<u>ansber</u>		Town or	Location of	of Death	Decemb		2005 ty of Death	7:27 P M
4	Examin	er	Memorial Hos	_		<i>(</i> 01)			ber1		n Coau			Legany	,
	Funeral		5. Social Security Number	6. Sex	7.	. Age (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir		9. Birthp	place (State or Foreign
	Director		217-28-7789	<u> 1</u>	M 2□F	73	Yrs.	Months	Days	Hours	MIII.	8. Date of Bir (Month, Da Jul 23,	1932	Cour	ИĎ
	and w		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c. Cit	ty, Town or Lo	cation							Od. Inside City Limits
	Maryl fish	ō	MD Alle	gany	,		Cumb	erlan	d						Y⊟Yes 2 No
	ith the Marylan or 28a-f show	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citizen o	f What Cour	ntry?
	th with	al D	8 W. Clement	Stree	t				2	1502			U	SA	
	tems	ner	11. Marital Status		2. Was Deced Armed Force	es?	I.S. 13.	Was Deced	dent of His	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	14. Ra	ace - Americ ack, White,	
36	rs afte	by F	1 ☐ Never Married X☐ M 3 ☐ Widowed 4 ☐ Divord		1 ∐ Yes 2 OXYes, Give Year or Dat		52	1 🗆 Yes	<b>2</b> √2 No	Specify:			Spec	ify: white	<del>.</del> .
5-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show cited Examiner must be multified at	ted	15. Deced	ent's Educ	ation		16a. Dece	dent's Usua	al Occupa	tion	A 6 d-1		16b. Kind of		
215	within 7 ene. than "n	Completed	(Specify only hig Elementary/Secondary (0-12		College (1-4	lor 5+)	life.	kind of wo DO NOT us	nk done d se retired,	uring mos	t of worki				
21	filed with Hygiene Ither than	Co	12	- (4)			clerk			10 Marks	-d- 11		A&P Ma		
Maryland	d be ental kad o	To Be	17. Father's Name (First, Midd Marvin Stan		V								Maiden Suma w Stans		
lary	2 shoul and M Is mari		19a. Informant's Name/Relation	nship (Typ	oe, Print)			-					er, City or Tow		
	ges 1 and 2 t of Health If itam 27 I		Jessie Stansb	erry	wife		Place of Dispo	Clen		Stree		Oate	erland	MD	
ore			20a. Method of Disposition  1  Burial 2  Crematic	n 3 □Re	emoval from SI	ate	cemetery, crei	natory or o	ther place	1			20c. Location	•	
Baltimore,	permit. Page Department of Important: If any injury of once.		*4 □Donation 5 □ Other  21. Signature of Funeral Servi		n 11	Sca	rpelli Fu	2. Name an	d Addres	s of Facilit	v		Cresa	otown	MD
Ba	Depar Impo any ir	0. 1	N/1/1/1/1		h//	U	1	Sca	arpelli	Funer	al Ho	me, PA Cumber	land MD	21502	
			23a. Part 1. Enter the disease shock, or heart failure. L	or complic ist only on	cations that cau	used the deat ch line.	th. Do not ent								Approximate Interval Between
	Pnysician	u l	Immediate Cause (Final disease or condition	a	aron	ic ol	skul	time	Pu	mo	na	Upi:	scarc		Onset and Death
	/Medical Examiner		resulting in death)		Due to (o	r as a consec	quence of):	- 11	1.		60	<u> </u>	Scarc		
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (o	r as a conseq	quence of):	eu	u	ing	G.	nus	-		1
$\checkmark$	cuted id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>	Coro	nar	u A	ster	u I	150	cas	e			
0,	al-tr		resulting in death) Last		Due to (o	r as a cons	ce of):		٠.	٨.		. 1 -			
8760	cate be c physician the buri	Physician/Medical		d	Caro	word	umo	nai	Y	77	re.	21-		-	
9 X	eath certifica attending ph I for use as t	/Me	IF FEMALE:	23	3c. If yes, outco	ome of prean	ancv						224 5	ate of delive	201
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?		1 Live bin	th 2 Feta	al death 3	Ectopic pr						onth	Day Year
0	the y th	hysi	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknov	vn							,		
S,	equires that sen signed b rould be deta	by P	Part II. Other significant cond	itions con	tributing to dea	th but not res	sulting in the u	nderlying c	ause give	n in Part I.	-				ne cause of death?
ord	w require been si should b	ted										1 🔼	Yes 2□No	3 🗌 Prob	pably 4 Unknown
of Vital Records,	aw las b	Completed										24a. Was autoj	osy	prior to co	psy findings available mpletion of cause of
al B	Th ate pag	Co										1 ☐ Yes	rmed? 2⊠ No	death? 1 ☐ Yes	2 🗆 No
Vita	Physician: The this certificate all director, pag	Be	25. Was case referred to med examiner?	_	ospital:		1500		Othe			(Check only o	one) dence 6 □0	-	
of	ding Phys	n: To	1 ☐ Yes 2X No 27. Manner of Death		28a. Date of (Month)		ER/Outpatier 28b. Time o		28c. Injury Work				dence 6 🗆 O		y)
ion	Attending F ir death. ector: After by the funer	atloi	1 X Natural 5 ☐ Per 2 ☐ Accident inve	ding stigation	(Month	, Day Year)	Injury	М		res 2 🗆	No				
Division	r Attender death	Certification:		mined	28e. Place o	f Injury - At h	iome, farm, sti	eet, factory	, office			28f. Location (a City or To	Street and Nun wn, State)	ber or Rura	N Route Number,
	ital o rs aft ral Di	Cer			<u> </u>										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical			sician: To the base.  and manne	is of examina									
	To the To the comp	Ň	29b. Signature and title of cert	fier	le			290	. License	number			29d. Date sign	ed (Month,	Day, Year)
	,		1	01					De	52429			Decemb	er 19,	, 2005
	5		30. Name and address of pers						105	, Cum	ber1	and, MI	2150	2	
	Sta	ite	31. Date filed (Month, Day, Ye		32 Ba	nistrar's Sign:	ature						-		١
	Regist	ar	DEC 2	1 201	05	elus.	H A	out	F						•

			For State Registrar	State of N	Maryland /		artment tificate			and M		giene	005	1.12	pro sereg
			1. Decedent's Name (First, Middle, Last,								2. Date of De	ath Day	Year	3. Time of E	Death
	Physici /Medic		Bever1y	Lee ST	ODDARD						Decemb	er 9,	2005	13:02	М
	Examin		4a. Facility Name (If not institution, give		r)		•		Location o	of Death			ounty of Dea		
			922 Frederick Str 5. Social Security Number 6. Se.		Age (In yrs. last	hirthday)	Hage If Under	erst	OWN If Under 2	24 Hrs	8. Date of Bir		shingt	on rthplace (State or	Fornisa
	Funeral Director			M 281F		Yrs.	Months	Days	Hours	Min.	(Month, Da May 9,	y, Year)	Ma	ryland	
	Maryland	tor	10a. State 10b. County Maryland Washingt	on	10c. City, To									10d. Inside City	
	h with the	al Direc	10e. Street and Number 922 Frederick Stre	eet			10f. Zip	Code 740					on of What C	ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Eracifical challed at ODGe.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 5 If Yes, Give Year or Dates	s? ☑ No		Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	I	Race - Am Black, Wh pecify: W		
Maryland 21215-0036	f within 72 ho plene. r than "natur the Medical	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 0-12			(Give life. L	dent's Usua kind of wor DO NOT us nemak	k done d e retired)	ition uring most	t of workii	ng		of Business	ŕ	
land;	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Clarence W. Ba	rnhart					18. Mothe		(First, Middle,				
, Mary	and 2 shorallth and No. 27 la ma		19a. Informant's Name/Relationship (7) Spencer E. Stodda								Hagers				740
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from Sta	(0)	stery, cren	sition (Nam natory or of en Cer	her place	ry   E	ecem 3, 2	ber 005			Town, State  , Maryla	and
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licens  Hole L.B. C.	anhen			. Name and				Minnicl d., Ha			lome laryland	2174
	Physician /Medical		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne ca <i>u</i> se on each	<sub>line.</sub> Metasta	tic ]				cardiac o	r respiratory a	rrest,		Approximate Interval Betwood Onset and De 10 year	eath
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	D	as a consequent										
8760,	ate be executed physician and the burial-transit	ical Examiner		Due to (or a	as a consequenc	ce of):									
.O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal dea	ath 3□	Ectopic pro					23	d. Date of de Month	olivery Day Ye	oar .
σŽ	Se Co	by	Part II. Other significant conditions $\infty$ $Pulm$	ntrib <i>u</i> ting to death		g in the ur	nderlying ca	use give	n in Part I.			obacco use Yes 2 <b>∑</b>		o the cause of dear	
Vital Records	The law ate has b page 2 s	Completed									24a. Was autop perfo 1  Yes		24b. Were a prior to death?	utopsy findings av completion of cau s 2 \( \text{No} \)	/ailable use of
Zit:	Physiclan: The this certificate ral director, page	Be c	25. Was case referred to medical examiner?	lospital:				Othe	e e		(Check only o		70		
of	ding h. After fune	tlon: To	1 Yes 2X No  27. Manner of Death  1X Natural 5 Pending 2 Accident investigation	1 ∐ inpa 28a. Date of Ir		Outpatien b. Time of Injury		Bc. Injury Work	4 🗆 190	2	ne 5 y Resident			əcify)	
Division	ter deal tor the	Certification:	3 Suicide 6 Could not be determined		Injury - At home etc. (Specify)	, larm, str	eet, factory	, office		2	281. Location (S City or Tox		Vumber or A	ural Route Numbe	e <i>r</i> ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exemi	sicien: To the be ner: On the basis and manner	of examination	dge, death and/or inv	occurred a	at the tim in my op	e, date an	d place, a th occurre	and due to the ed at the time,	cause(s) ar date and p	nd manner a lace, and du	s stated. e to the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifes		>			License						th, Day, Year)	
- 17			30. Name and address of person who co	onapleted cause o	I death (Item 23	a) (Type,		_0000	<i>.</i>			Decel	IDEL 9	, 2005	
	H-5-1		Allen W. Ditto	747 Nor					town,	Mar	yland				
	Sta Registi		31. Date liled (Month Day, Year) 20		strar's Signature										

	1	For State Registrar	State of Mary		artment of H			iene 0 0 5	41258
بري کي		Decedent's Name (First, Middle, Last	)				2. Date of Deat Month		3. Time of Death
Physicia /Medica	al -	George Washing					Decembe:		9:30 PM
Examine	r	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
Eumanal		1004 View Stre	x 7. Age (In	yrs. last birthday)	Hage If Under 1 Year	rstown If Under 24 Hrs.	8. Date of Birth (Month, Day,	Washingt 9. Bir	on County
Funeral Director		215–14–1280 <sup>1X</sup>	M 2□F	84 Yrs.	Months Days	Hours Min.	(Month, Day, June 1		thplace (State of Foreign puntry) ryland
pu .		Usual Residence of Decedent  10a, State 10b, County	100	c. City, Town or Lo	cation				10d. Inside City Limits
Aaryla F shore	_	1			erstown				XX Yes 2 □ No
the N	<u>۔</u>	Maryland Washing  10e. Street and Number	COIT	Tiag	10f. Zip Code		1	0g. Citizen of What Co	ountry?
h with	Funeral Directo	1004 View Stree	ŧt		21	740		U.S.A	_
ems erm	Iner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.1	Was Decedent of Hi	ispanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
s afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 📉Yes 2 🗌 No If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:	,		White
be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "netural", or items 23a or 28a-f show event, the Medical Examinar must be notified at		15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occupa	ation	-	16b. Kind of Business	/Industry
Anin 72	Completed	(Specify only highest grad	de completed)  College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of worki )	ng		•
ed will	Sol	12		I	ndustrial	Engineer		Aircraft	Mfg.
d be fill the out the	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		ŕ	
hould he mark	0	Lewis H. Stale  19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street a			Lister Sta City or Town, State,	
nd 2 sulth an 27 ls		Gregory A. Stale			-			THE SECTION SEC	yland 21042
as 1 a of Hear item		20a. Method of Disposition	20	<ol> <li>Place of Dispo cemetery, crer</li> </ol>	sition (Name of natory or other place	e)   C	ate	20c. Location · City or	Town, State
Page Page Thent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Rest Have	en Cemeter	ry   12–1	0-05	Hagerstown	n Maryland
partitione, interpretation and process and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural; or items 23a or 28a-f show eny injury or other treumstic event, the Medical Exambar must be notified at once.		21. Signature of Funeral Service Licens	A Fine	17127-00	2. Name and Addres	10	uglas A. N. Hager	Fiery Fur	neral Home Vland 21742
	1	23a. Part1. Enter the sease, or comp shock, or heart lai ure. List only o	lications that seed the ne cause ach line.						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a.	ac	cit my	ocarbial	INONE	hou	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):	1				
CA ST	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):					
uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter fundantying Cause (Disease or injury that initiated events							
e exector and an	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):					
ate be executed hysician and the burial-transit	Ical		d			<del></del>			
wrequires that the death certificate signed by the attending phe should be detached for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy					
eath cer attendir for use	clan	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
the d ached	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		2 (4,10. (4,500.1))				
s that	by P	Part II. Other significant conditions co	ė - · · ·	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	oacco use contribute to	the cause of death?
law requires that see that see the signer of the see the signer of the see that see		- ly Pa	evernar				1 □ Ye	s 2 □No 3 □ Pr	obably 4 🗷 Unknown
law rate be 2 sh	Completed	r					24a. Was ar	y prior to	utopsy findings available completion of cause of
cate h	ទី						perform 1 Tes 2	ned? death? 2 No 1 ☐ Yes	2 🗆 No
VICAL sicien: Certifica rector, p	Re	25. Was case referred to medical examiner?	Hospital:	- T-510	Othe	26. Place of Death			
Attending Physicien: The law sr death.  rector: After this certificate has by the funeral director, page 2:	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatien	I SELDON	4   Nursing Hor		nce 6 Other (Spe w injury occurred	cify)
Attending at death.  ector: After by the fune	atlo	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		t? Yes 2 □ No			
r Atts fer de linecto	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · building, etc. (Sp	At home, farm, str	eet, factory, office	2	8f. Location (Str City or Town	reet and Number or Ro , State)	ural Route Number,
urs af									
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1. ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	rsician: To the best of my iner: On the basis of examination and manner stated.	y knowledge, death mination and/or in	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ad at the time, da	iuse(s) and manner as ate and place, and due	s stated. e to the cause(s)
Fo the vithin comple	Σ ·	29b. Signature and title of certifier	<u> </u>	4	29c. License		29	d. Date signed (Mont	h, Day, Year)
. ,, , ,		1,520	Pulivar	h'	05	0233		12/9/05	
e il ili		30. Name and address of person who o	ν Λ		Print) AA 1	21742	_		
5H-14+1		31. Date filed (Month, Day, Year)	32. Registrar's S	tagersto	un Irla	41172			
Stat Registra		DEC 122	. 2	A. 1	locales				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mar	yland		ment of H icate of L		nd Mental I	Hygiene Reg. No.	AAS	11259
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La  Edward Scl  4a. Facility Name (If not institution, giv  UNIV of Maryland	owartz	,		City, Town, or	Location of		- 8 <sup>a</sup>	Year 200 County of Dea	
	Funeral Director		5. Social Security Number 6. S		In yrs. las	t birthday) If	Under 1 Year onths Days	If Under 2- Hours	4 Hrs.   8 Date of	Birth Day, Year) 11,195	9. Bi	more City hthplace (State or Foreign ountry) nnsylvania
1000 cm	28a-f show	ector	10a. State 10b. County Pa. Frankl:			own or Location				10a, Citi	izen of What C	10d. Inside City Limits 1 Yes 2 No
è		by Funeral Director	5062 Wright Ro	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No	er in U.S.	13. Was	1		in? (Specify Yes o Puerto Rican, etc.			S.A erican Indian,
21215-0036	giene. sr than "natural" tre Madical Ex	Completed b	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	Year or Dates: ducation ade completed)  College (1-4or 5+)		16a. Decedent' (Give kind life. DO f	s Usual Occupa of work done o NOT use retired Mechan	during most ( )	of working	16b. Ki	ind of Business	s/Industry Auto
aryiand	and Mental Hygins and Mental Hygins Is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last Walter A. Sc.  19a. Informant's Name/Relationship (	hwartz Jr. Type, Print)				and Number	or Rural Route Nu	J. Re	eeder r Town, State,	Zip Code)
more, m	perint. rages rand Department of Health Important: If Itam 27 i eny injury or other tra		Karen Schwartz  20a. Method of Disposition  1 2 Burial 2 Cremation 3 C 4 Donation 5 Other (Specia		20b. Plac	e of Disposition letery, cremato Lawn Me Garde	n (Name of ry or other plac	θ)	Date Dec. 12, 2005	20c. Lo	ocation - City o	r Town, State
Баітішо	Departm Importa eny inju		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or com	Davis,	Mol	22. Na	me and Addres Davis	Fune:	ral Home	Smiths		ry Ave. d. 21783
90,	hysician //Medical purial-transit the purial-transit	lical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cirr Due to (or as a complete of the comple	consequer	nce of):	er di	seas	i e			Interval Between Onset and Death
	nding p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal de	eath 3 ⊟Ect	opic pregnancy ner (specify)				23d. Date of de Month	elivery Day Year
ords, P.	Miequiles lital free deali been signed by the ette should be detached for	by	Part II. Other significant conditions of SCPSIS	contributing to death but	not resulti	ng in the under	lying cause give	en in Part I.	1	□Yes 2	Mo 3 □ P	to the cause of death?
r	ate has	Be Completed	25. Was case referred to medical examiner?					26. Place of	a		prior to death?	
5	After this funeral di	Certification: To	1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	OB Place of Injur	Year) 28	Bb. Time of Injury		4 🗀 14013	lo	ibe how injur	y occurred	ecify) Bural Route Number.
בֿ	Tospital or 4 hours afte Funers! Dir ely filled in	edical Certif	4 Homicide determined	building, etc.  hysician: To the best of miner: On the basis of eand manner state	my knowle	edge, death occ	curred at the tim	ne, date and pinion, death	City or	Town, State	and manner a	s stated.
, ,	within 2-	Mec	29b. Signature and the oboartitier	M.D		20) (7		1835		Dec		nth, Day, Year)
5H	* Sta		30. Name and addless of person who Fathryn St.  31. Date filed (Month, Day, Year)	completed cause of dea	tin (Item 2 2,2, S 's Signatur	Sa) (Type, Prin	reene S	it B	altimore	Mar	yland	21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg.No.U Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Voar **Physician** ETHEL VIRGINIA SMITH 10, 10:10 p<sup>M</sup> 2005 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REEDERS MEMORIAL HOME **BOONSBORO** WASHINGTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
JULY 9, 1912 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 93 Yrs MÄRYLAND 219-46-3228 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f ehov must be notified at 1X Yes 2 □ No Director BOONSBORO MARYLAND WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 141 S. MAIN STREET Items 23a Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. other treumatic event, the Medical Exertiner iled within 72 hours after 1 Never Married 2 Married ö 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other t 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be ls marked of should be FLORENCE MAY FOCKLER JAMES CLIFTON SMITH lary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 I 31 LEHIGH SVENUE, HAGERSTOWN, MARYLAND DOROTHY C. ALEXANDER, NIECE timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or BROWNSVILLE HGTS.CEM: 12/15, 2005 BROWNSVILLE, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sineral Service Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 Pirt1. clarine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician numonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZX No 2 Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours a To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 11 2005 44996

SH-3

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

20311 Lappans Rd. Boonsboro, MD 21713 /301-432-8470 32. Registrar's Signature

Dr. Zafar Malik DEC 1 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ALDEN WILCOX SANFORD DECEMBER 4, 6:15 P. M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROFTON ANNE ARUNDEL CROFTON CONVALESCENT CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1MM 2□F Months Director 013-07-0096 87 08/13/1918 MASSACHUSETTS Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f show 27 is marked other than "natural", or Itema 23a or 28a-f shov traumatic event, the Nuclical Examinations for motified at tv☐Yes 2☐No MARYLAND PRINCE GEORGES BOWIE Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? With USA 12318 WHITEHALL DRIVE 20715 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. SUPERVISOR 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ CHESTER OULTON SANFORD ETHEL JOSEPHINE WILCOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 i 12318 WHITEHALL DRIVE BOWIE, MD 20715 ADELE FRONCZEK/ DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of the Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MAIN STREET CEMETERY | 12/9/2005 ROWLEY, MASSACHUSETTS 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 16000 ANNAPOLIS ROAD BOWIE, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final /ascul an Dementia Pnysician disease or condition resulting in death) /Medical Condio Versculan Distan Examiner ber tensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury D to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 1-0 that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2[] No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 2 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiei Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2010 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA, M.D. 14300 GALLANT FOX LANE SUITE 222 BOWIE, MD 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **DEC 0 6 2005** 

nend item#	State of Maryland / Department of Health and 1- State Registrar 18perfh, bg, 12/8/05 & #31 perCertificate of Death phy	Mental Hygie y.12/9/05**9.	ne2005 4126:
Physician /Medical	1. Decedent's Name (First, Middle, Last) The Incl Sutton	2. Date of Death Month	Day Yeer 3. Time of Death 7 2005 A M
Examiner Funeral	4a. Facility Name (If not institution, give street and number)  Deers Hend Hespital Center Salichury.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 year If Under 24 Hr.	s. 8, Date of Birth	4c. County of Death  Wi Co Wi Co  9. Birthplace (State or Foreign Country)
Director	23 0 - 26 - 3760 1 M 2 F 76 Yrs. Months Days Hours Min Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
of the death with the Marylan reference 23e or 28e-1 ehow unsert case to motified at Funeral Director	MD SOMETSEL Cristield  100. Street and Number  24 Somers Cove Apts. 21817	10g.	1 ☐ Yes 2 Trice  Citizen of What Country?
ifter des	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Specify:  1 □ Ves 2 □ No Specify:	Specify Yes or No- orto Rican, etc.)	14. Race - American Indian, Black, White, etc.
n 72 n 72	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  LA DOTEV  18. Mother's Name	orking	5 EA Fo ad
Te, Widl yidilu 2 LE, Widl yidilu 2 LE, Theath and Mental Hygiene. The Health and Mental Hygiene item 2 Le marked other than other traumatic event, the MTE TO Be Comp	19a. Informant's Name/Relationship (Type, Print) dayginter  19b. Mailing Address (Street and Number or F	In Rick	neg Pinkney
2 = 0 = 5	VERONICA MCCREADY   217 Poplar St. 2C     20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   128     14   Donation 5   Other (Specify)   12   13   14   15   15   15   15     15   16   17   17   17   17   17   17   17	Frui Tlanc	
permit. P Departme Important any injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility  Fulfory E. Wards. 30639 HAM pdish	AUE. Cr	is Field Frinces
Physician /Medical Examiner	23a. Part. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failing. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Failure to thrive Due to (or as a consequence of):  End staye Renal disease of the first of the	ac or respiratory arrest,	Approximate Interval Between Onset and Death Weeks
cate be executed by sicien and the burial-transit dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Dee Vein thrombosi  Due to (or sa consequence of):  C. Ongertive Meant Failure	e Lejs	Months Years
that the death certificate ad by the attending phys detached for use as the	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypothysociation.		co use contribute to the cause of death? 2 No 3 Probably 4 nknow
cian: The law requir certificate has been si ector, page 2 should Be Completed	Hypertension Anemia	24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
ling Phys	examiner?  1   Yes   2   No	Home 5 Residence 28d. Describe how i	injury occurred
oital or Att urs after d oral Direct illed in by	4 Homicide determined building, etc. (Specify)	City or Town, S	
To the Hospital or Attention within 24 hours after deat for the Funeral Director completely filled in by the Medical Certifical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date occ	curred at the time, date	and place, and due to the cause(s)
	29b. Signature and title of certifier  Staff physician D6063368  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DON'T HYUN LEE, 2018 Paar's Head Happed  31. Date filed (Month, Day, Year)  32. Register's Signature  DEC 0 9 2005 Register's Signature	/	12/7/2007
State Registrar	31. Date filed (Month, Day, Year)  32. Register's Signature  DEC 0 9 2005	Road. S	alubury 1-10 2/80/

			State of Maryland / Department of Health and I  1- Stete Registrar Certificate of Death	, ,	2005	11001
			110grandi	2. Date of Death	. Nó. U U J	4/264
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Month November	Day 27, 2005	3. Time of Death
	/Medic		Ruth K. Schneider  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deat	7.5011
	Examin	er	9707 Old Georgetown Road, Apt. 2104  Bethesda	"	Montgom	
н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		9. Birt	hplace (State or Foreign
	Funeral Director		546-26-2176 1 M 2 F 91 Yrs. Months Days Hours Min.	\$ept. 28,	1914 Ca	lifornia
	ס	Ì	Usual Residence of Decedent			
	urylar show	_	10a. State   10b. County   10c. City, Town or Location   Maryland   Montgomery   Bethesda			10d. Inside City Limits 1 AYes 2 No
	8a-1 g	ct				
	vith th	Director	10e. Street and Number 10f. Zip Code	1	. Citizen of What Co	,
	s 23g	Funeral	9707 Old Georgetown Road Apt. 2104 20814  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Ame	s of America
_	Itam Itam	un.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent of Hispanic Origin? (S	to Rican, etc.)	Black, White	e, etc.
2	urs af	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Wh	ite
Ş	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	rting 16	b. Kind of Business/	Industry
Z	thin 7	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	K///g		
7	ygien ygien yar th	S	4 Homemaker		Own Hom	e
מ	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itams 23e or 28e-f show umstic event, the Medical Evapor er must be notified at	Be		me <i>(First, Middl</i> e, <i>Ma</i> n Goldsmit		
2	d Mer narke	P				7- O- 1-)
Maryland 21215-0036	C1 10 -0 15		19a. Informant's Name/Relationship (Type, Print)  Lynne Sneiderman - Daughter  19b. Mailing Address (Street and Number or Ru 6806 Tammy Court, Bet			ip Code)
_	1 and Health Iom 27		20a Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City or	Town, State
<u></u>	Pages nnt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  1 ☐ Crematory or other place)  Metropolitan Crematory 11/	/29/05 A	lexandria	. VA
Baltimore,	permit. F Departme Importar any injur	- 1	21. Signature of Fundal Service Icensee * Edward Sage Funera			
ñ	lmp any any		1091 Rockville Pike			852
П			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Cerebrovascular Accident			Onset and Death Hours
	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b.			
	ed sit	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, Disease or injury			
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ROX	eath certific attending p I for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	very
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	res thai igned h		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to 2 XNo 3 ☐ Pro	
Records,	w require been sign	Completed		I Yes	2121NO 3   PR	obably 4 Unknown
ec	alaw hasb e 2 sł	nple		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
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on	ding h. After fune	tlon	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No	200. 0000.00 11011	injury occurred	
Division of	or Attanding Physician: titer death. Diractor: After this certific in by the funeral director.	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		et and Number or Ru	ral Route Number,
5	al or safter	Certification:	4  Homicide building, etc. (Specify)	City or Town,	State)	1
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier  (Check only   Medical Exeminer: On the bast of my knowledge, death occurred at the time, date and place   2   Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the cau	se(s) and manner as	stated.
	the H in 24 tha F nplete	fedical	one) and manner stated.			
	To To	2	29b. Signature and title of certifier 29c. License number		. Date signed (Month	
	70	,	Mohen leng 10 D0058645	N	ovember 2	8, 2005
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Andrea Karp, MD 10810 Connecticut Ave. Kensingto	on. MD 208	95	
	Sta	te		J.1.5 THD 200		
	Registr	_	31. Date filed (Month, Day, Year) DEC 0 6 2005  32. Registrar's Signature			

SMITH, ALBERT

**Funeral** 

Director

ns 23a or 28a-f show

r than "natural", or itams the Medical Examiner ma

death with the Maryland

Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lieu	1600	Lewis	N. Watson I Vest Road, S	
Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  It is a few after death.  It is certificate has been signed by the attending physician and in proposition in the few after this certificate has been signed by the attending physician and in proposition in propo	dical Examiner	23a PertT. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).	Do not enter the model of the second of the		
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Division of Vital Records, P	w requires that s been signed t should be det	eleted by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying o	ause given in Part I.	23e
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ita	inn:	Be	25. Was case referred to medical examiner?			26. Plage of I	Death (Check
-	aysic lis ce dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 D	OA Other: 4 Nursin	gHome 5□
ion o	nding Pt ath. r: After the		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Des
Divis	o Hospital or Attendi 24 hours after death. Funeral Director: A stely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor	y, office	28f. Loca City
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	(Check only 2 Medical Examone)	lysician: To the best of my knowniner: On the basis of examinat and manner stated.	ion and/or investigation	n, in my opinion, death o	ace, and due ccurred at the
	5 C		29b. Signature and title of certifier	Can		C. License number	7/
		1	20 Name and address of nerson who	completed cause of death (Item	23a1 (Type Print)		

DEC 0 5 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Nov. 28,2005 11:35 P M Albert E. Smith /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY, MD. 21804 WICOMICO SALISBURY REHAB & NURSING CENTER If Under 1 Year If Under 24 Hrs. Min. (Month Day, Year)

Oct 2, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1₩ M 2□ F MD 215-20-4314 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Somerset Chance MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Mitchell Beckett Rd. 21821 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ ₩es 2 □ No
I Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Waterman Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert E. Smith Sr. Edith Hitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Serena Wright/sister-in-law 10821 Toddville Rd., Chance, MD 21821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Charles UMC Cem 12/3/2005 Chance, MD Home ry, MD 21801 Approximate Interval Between Onset and Death tory arrest, 23d. Date of delivery Month . Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Was an autopsy performed? Yes 2 No only one) Residence 6 Other (Specify) scribe how injury occurred ation (Street and Number or Rural Route Number, or Town, State) to the cause(s) and manner as stated. time, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#11 per INF C852 2/24/06 CC

Per INF C852 2/24/06 CC

Per INF C852 2/24/06 CC

Per INF C852 2/24/06 CC

Per INF C852 2/24/06 CC

Per INF C852 2/24/06 CC

			- Sta <b>Amend Items/ 1&amp;17</b> Registrar	per PHYSEH C852	2. 2/24/06	Micate of	Death	, ,	leg. No.	
	Physicia	ja:	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	th of O Oy	3. Time of Death
	/Medic				RICARDO			1,2	04 20	
	Examin	er	4a. Facility Name (If not institution, give Washington Advent			Takoma	r Location of Death Dark		4c. County of	omery County
	Funeral	S .	Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year	II Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
30 M	Director		579-06-5221	<b>∑</b> M 2□F	60 Yrs.	Months Days	Hours Min.	April 2		Morazan.
	pu »		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ncation			E	
	faryla sho	5	MD Prince C		yattsvi.					1 1 Yes 2 □ No
	28a-	rect	10e. Street and Number	leorges II	yattsvi.	10f. Zip Code		1	10g. Citizen of Wha	
	h with	Funeral Director	4922 Lassalle Ro	na d		20782			El Salva	ador
	deat	ner	11. Marital Slatus	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Black	American Indian, White, etc.
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or itema 23e or 28e-f show imarke event, it a Modical Exabilist matte event, it a Modical Exabilist matter.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ZNo If Yes, Give	i i		Specify: Salv		Specify:	
2	hour	ed b	15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occup	El Salv	i	EL-Sa 16b. Kind of Busin	lvadorian ness/Industry
212	be filed within 72 hc tal Hygiene. d other than "natu event, IV e Miculan	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ang	Miller 8	& Long
2	ed with	Com	8th		Labor	rer			Construc	ction
ng	be file	Be	17. Father's Name (First, Middle, Last)  Mariano Salaman		<b>.</b>		18. Mother's Nam		Maiden Sumame)	
$\frac{8}{5}$	should be filed within the Mental Hygiene. marked other than matte event, If a M	70	19a. Informant's Name/Relationship	OTHEROWI		na Addrass (Straat	and Number or Rui			ata Zin Codo)
Maryland 21215-0036	0 4 4 4		Francisca Branch				lle Dr. E			
ē,	s 1 and if Health item 27 other tr		20a. Method of Disposition		o. Place of Dispo	osition (Name of matory or other pla		Date	20c. Location - Ci	
Ë	Pages nent of int: If it		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ry Of Int		cember 2	23,2005 E	El Salvador
Baltimore,	permit. Pages Department of important: If it any injury or o		21. Signature of Funeral Service Liter	isee	2:	Austin R	oyster Fu			
ш	20.5 3		Cyu.			3821 14t	h Street	NW Wash	ington I	C 20011
4			23a. Part1. Enter the disease or comshock or heart failure. List only	one cause on each line.	eath. Do not en	ter the mode of dyli	ng, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediale Cause (Final disease or condition resulting in dealh)	a. Oneumer			<u>.</u>		<del></del>	
- 50	Examiner			Due to (or as a cons	sequence of):					
(A)		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	sequence of):					
	rcuted nd transit	Examiner	that initiated events	c						
90,	be execien a		resulting in death) Last	Due to (or as a cons	sequence of):					
68760,	ficate be executed physicien and is the burial-transit	Medical		d						
	The law requires that the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		75			23d. Dale o	of delivery
P.O. Box	death ne atte ed for	Physician/	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Dectopic pregnance Other (specify)	y		Month	n Day Year
P.O	n requires that the de been signed by the s should be detached	Phys	9 Unknown					ana Didaa	h	uta la tha sauca of death 2
	ires th signed	þ	Part II. Other significant conditions of		resulting in the u	inderlying cause giv	en in Part I.			ute to the cause of death?
Š	r requ been shouk	etec	Encephalopa	un7				24a. Was a		
Records,	he lav a has ige 2	Completed						autop: perfor	sy price dea	re autopsy findings available or to completion of cause of alh?
	an: T tificate tor, pa	Be Co	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		Yes 2□ No
₹	Physician: r this certifica ral director, p	To B	examiner? 1 Tes 2 No	Hospital: 1 Thipatient 2	⊇ ☐ ER/Outpatie	nt 3 DOA Ott			ence 6 Other	(Specify)
0	ng Pł kiter tł uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo		28d. Describe h	ow injury occurred	
Sio	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b	e On- Blace of Injury A	t home form at		Yes 2 No	28f Location (S	Street and Number	or Rural Route Number,
Division of Vital	i or A after Direct	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	reet, ractory, onice		City or Tow		or Abrai Addie Whitber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	nysicien: To the best of my	knowledge, deal	th occurred at the ti	me, date and place	and due to the d	ause(s) and mann	er as stated.
	in 24 in 24 ihe Fu	Medical	one)	niner: On the basis of exam and manner stated.	nination and/or in					
	To To Com	2	29b. Signature and title of certifier	· Uar MT	)	29c. Licens	3:103	4	29d. Date signed (	**
,	4				<u> </u>				12/04/	05
	1		30. Name and address of person who SABYASACA1	WAR TE	De Coro	rue Aven	mp - 7	20917		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	rated		VIZ		
	Regist	ar	DEC 0 7 20	105 300000000000000000000000000000000000	15. Popular					

		1	For State Registrar	State of	of Marylan	*	artment rtificate				ental H	ygien Reg. Ne	005	41267
~ 4		J.W	1. Decedent's Name (First, Midd	lle, Last)						2	2. Date of D	eath Da	ay Year	3. Time of Death
	Physici /Medio		Laurence	Sewell_						]			26, 2005	10:53 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution	on, give street and nu	ım <i>ber)</i>		4b. City, T	Fown, or	Location of	of Death		40	c. County of Deat	th
12		e>- <b>~</b>	Washington Ad			to a black do b	Tak		Park		D-114 D		Montgome	J
	Funeral		5. Social Security Number 577–50–1200	6. Sex 1 <u>≰</u> M 2 ☐ F	7. Age (In yrs. 68			Days	Hours	Min.	B. Date of B. (Month, C	day, Year	9. Birt Co	hplace (State or Foreign buntry)
3	Director		Usual Residence of Decedent								ED. 10	0, 1.	JJ/ Wash	ington, D.C.
	yland		10a. State 10b. Count	У		y, Town or Lo								10d. Inside City Limits
	e Ma	Funeral Director	D.C.		Wa	shingt	on					Ţ		1X Yes 2 No
	ith th	Dire	10e. Street and Number				10f. Zip						itizen of What Co	-
	ath w	rai	2235 Savannah			6 10		0020		-:-2 /0	4. V h		nited St	
	er de	une	11. Marital Status  1 X Never Married 2 ☐ Ma	Armed F	cedent Ever in U. orces? 2 ∰ No	.5.	Was Decede If Yes, speci	ify Cuba	n, Mexicar	n, Puerto R	ican, etc.)	10-	Black, Whit	
36	irs aff	by	3 ☐ Widowed 4 ☐ Divorce	If Yes, G	ive **		1 ☐ Yes 2	No ∑	Specify:				Specify: B1	.ack
9	be filed within 72 hours after death with the Maryland ital hygiene. id other then "natural", or iteme 23s or 28s-f show event, it a Medical Esaminar must be notified at	Completed		nt's Education	1	16a. Dece	dent's Usual kind of work	I Occupa	ation	t of working		16b. i	Kind of Business/	Industry
218	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	DO NOT us	e retired	)	il or working	•			
21	ed wi	Son	12			Pr	oduce	Mar			(F) . A 6' -4-4		afeway F	oods
pu	12 should be filed within 7 h and Mental Hygiene. 7 ie marked other then "rireumatic event, the Mental	Be	17. Father's Name (First, Middle	, Last)									n Sumame)	
2	hould d Mer narke	P	George Sewell	ship (Type P.int)		19h Maili	na Address	(Street a		anor			or Town, State, 2	Zin Codel
Maryland 21215-0036	d 2 sl th an th an traur	li	Josephine Hil				Dellw							
	ges 1 and 2 should t of Health and Mer if Item 27 is marks or other traumatic		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nam	e of	01	Da	te	20c. L	ocation - City or	Town, State
OE.	Pages ent of nt: if i		14 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State	emetery, cred				ec.3.	2005	Bre	ntwood,	Md.
Baltimore,	permit. Pages Department of I important: if its any injury or of		21. Signature of Funeral Service	1	V/=	2:	2. Name and	d Addres	s of Facili	tv				
ä	Depa impo any ir		ATTHE A.	Stare o	MOINT	T 4	3538°M	laer Larit	ooro r	Pike7	Fores	tvil	mes, Md.	20747
N. S.			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that st only one cause on	caused the deat	h. Do not en	ter the mode	e of dying	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. (	andia	- Must	satte.							Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):								
. a-	LAMITHE	ē	Sequentially list conditions,	b	for as a consis	uence of								
	led nsit	nine	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the cause)	₹	that are at controlled	Creative Arg								
	be executed icien and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
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9	tificate ig physias the	ledi												
Вох	requires that the death certific neen signed by the attending p hould be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Peta		☐Ectopic pre	egnancy					23d. Date of de	,
	e deal the att	sicia	in the past 12 months? 1  Yes 2 No		nant at time of d		Other (spe						Month	Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown  Part II. Other significant condi	tions contributing to	death but not ree	ulting in the u	ndorhina as	auco auc	on in Part I		23e Dic	1 tobacco	use contribute to	the cause of death?
JS,	uires th signe Id be d	اھ	Fad Cl-	P a	A C		indenying ca	ause give	en in raiti					robably 4 Unknown
Ö	w requ	etec	C	(6)										
Rec	e lav	Completed	) eps. ?	<u></u>							24a. We	lopsy formed?	prior to death?	utopsy findings available completion of cause of
a		e Co	25. Was asserted to modifie						00 Pl	- 10	1 Yes		o 1 ☐ Yes	2 □ No
Ę	Physician: this certific ral director,	00	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt _ 3∏ DO.	A Othe	0.5	e of Death			6 □Other (Spe	cofu)
ō		n: To	27. Manner of Death	28a. Date	of Injury ofth, Day Year)	28b. Time o		8c. Injury Work	1 144				ury occurred	City)
ion	Attending Ir death. ector: After by the funer	atio	Z C Modidom	tigation	nui, Day 19ai)	Injury	М		Yes 2	No				
Division of Vital Records,		Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined 489. Plat	e of Injury - At he	ome, farm, st	reet, factory,	, office		28	Bf. Location City or T	(Street a	and Number or Ri	ural Route Number,
Ō	ital or rs afte rai Dir led in	Cer												
	To the Hoepital or within 24 hours at To the Funeral D completely filled in	edicai	(Check only 2 Medica	ing Physician: To the Examiner: On the	basis of examina									
	the the the mplet	Med	one)  29b. Signature and the of certification of certification of the ce		nner stated.		29c	License	e number			29d. D	ate signed (Mont	h. Dav. Year
	F. ¥ F. 8				کاور د			0	450	564		1	1/26/	2005
	7		30. Name address of person	in who completed cal	of death (Iter	n 23a) (Type,	Print)			$\rightarrow$				718
2	(10)		14300, 6	ALLAN			J, 1	M	U	SIL	ie		11) Le	+10
10	St. Regist	ate rar	31. Date filed (Month, Day, Yea DEC 0 6	2005	Registrar's Signa	ature	المك							

			For State	State of		d / Depa	artment	of H	ealth a		lental Hy		O O =		
			Registrar  1. Decedent's Name (First, Middle,	( act)		Cel	tificate	OIL	Jeath		2. Date of De	Reg. No.	UUD	2 time 3	6.8
	Physicia	an									Month	Day	Year 2005	0350	AR M
	/Medic		Helen Pauline S <sub>1</sub> 4a. Facility Name (If not institution, g		ber)		4b. City, T	Fown, or	Location of	of Death	ресешье		County of Deat		AM
	Examin	C1	Homewood Of Will:		,		Willi						shingto		
_	Funeral	(=)		. Sex	7. Age (In yrs.		If Under		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da			nplace (State ountry)	or Foreign
	Director		235-32-6953	1 □ M 2 🕅 F	80	O Yrs.	WOTUS	Days	110013		Sept.	11,19	25 West	Virgi	nia_
	*	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
- Paragraphic	de de	ö			77								,		2 □ No
And the state of t	28a-	Director	Maryland Wash:  10e. Street and Number	ington	Ha	agersto	10f. Zip	Code				10g. Citiz	zen of What Co	untry?	
4	3a or		423 Michigan Av	zenue			21	740				US	SA	14.7	
	E E	ner	11. Marital Status	12. Was Dece		.S. 13.			spanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White		
و و	or ite	by Funerai	1 ☐ Never Married 2 ☐ Married		2 🔀 No		1 ☐ Yes 2			, 1 40110	riouri, oto.,		Specify: Wh		
21212-003b	tural, or ite		3 ☑ Widowed 4 □ Divorced	Year or Da	ites:									•	
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7	than	m o	Elementary/Secondary (0-12)	College (1-	-4or 5+)	1	orer	,					ıfacturi	ing	
B :	is living with the mous are local must be waryantal hygiene. d other than "natural", or items 23a or 28a-f show event. The Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, La	ist)					18. Mothe	r's Nam	e (First, Middle				
land		To B	Asby Himelwrig	ght					Da	isy	LaFolet	te			
Mary	t and z should t Health and Men Item 27 is marke other traumetic		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbe	or Run	al Route Numb	er, City or	r Town, State, Z	(ip Code)	
G.	Health Health Hem 27 Sther tr		Gary W. Spaid	/Son					Avenu				Md. 217		
0	rages i a nent of Hea nut: If item ury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3	B □Removal from S	State	Place of Dispo cemetery, crei	natory or ot	her place			Date		cation - City or		
			`4 □Donation 5 □Other (Spe		Re								erstown		Land
g	Departi Departi Import any inj		21. Signature of Funeral Service Li	censee									neral C town, M	C. C. C. St. 120-120-120-120-120-120-120-120-120-120-	2
			23a. Part1. Enter the disease, or o	om allions that ca	used the deat				-		-	_	LOWII, FI	Approximat	te
			shock, or heart failure. List or Immediate Cause (Final	nly one cause on ea	ach line.	20-	V		NT		,	,		Interval Bel	tween
	hysician /Medical		disease or condition resulting in death)	a. Due to (	or as a consec	Mence of):	DE	m	7011					MANIT	13
E	xaminer				or 43 4 3011304	quonos ory.									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (	or as a consec	quence of):									
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	с											
/60,	ian a		resulting in death) Last	Due to (	or as a consec	quence of):									
	9 % 9	dicai	,	d											
χ Σ	The law requires that the beam certained the has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outo	come of prean	ancv						2	23d. Date of deli	ven/	
ROX POX	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	irth 2 Feta	al death 3[	Ectopic pre						Month Month	-	Year
oj j	inat ine de ned by the a detached t	iskr	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkno				,,							
J	es man igned b	by PI	Part II. Other significant condition	s contributing to de	ath but not res	sulting on the u	nderlying ca	use give	en in Part I.		23e. Did t	obacco u	se contribute to	the cause of	death?
Records,	w require been sig should b	edt	CHIMIN C C	135 Muc	TIME	Tuc	min	M	4_		1 🗆	Yes 2	□No 3 Pr	obably 4 🗍	Unknown
ဝ	has bei	piet	DISITSE			<b>,</b>					24a. Was		24b. Were au	topsy findings	available
		Completed	•								perfo	rmed? 2 No	death? 1 ☐ Yes	2 □ No	
Vital	ding Physicien: The h. h. After this certificate ha funeral director, page	Be (	25. Was case referred to medical examiner?							of Deat	h (Check only o	опе)			
0	this o	၉	1 Yes 2 No		npatient 2			100	4 100	rsing Ho			Other (Spec	cify)	
ב מ	After	ion	27. Manner of Death  1 □ Vatural 5 □ Pending		of Injury h, Day Year)	28b. Time o Injury	M 28	Bc. Injury Work	≀at ⟨? Yes 2 🗍	No	28d. Describe	now injury	y occurred		
DIVISION	death ctor: / the	icat	2 Accident investiga 3 Suicide 6 Could no	t bo	of Injury - At h	ome, farm, st			163 2	140	28f. Location (	Street and	d Number or Ru	ral Route Num	nber.
<u>≥</u> :	after Direction by	Certification;	4 Homicide determin	buildir	of Injury - At h ng, etc. (Speci	fy)	out, lactory	, omoo			City or To				,
_	spira nours norel		29a. Certifier 1 Certifying	Physician: To the	best of my kno	owi <b>edg</b> e, deat	h occurred a	at the tim	ne, date an	id place,	and due to the	cause(s)	and manner as	stated.	
	I o the nospital of Attending Prysicient, within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	Medicai	(Check only 2 1 Medicel E	xaminer: On the ba and mann		ation and/or in	vestigation,	in my op	oinion, dea	ith occur	red at the time,	date and	place, and due	to the cause(s	s)
1	withii To the	ž	29b. Signatur and dita di cariner	)4	X		29c.	License	number	-		29d. Date	e signed (Mont)	, Day, Year)	
			MEMIX	/MED(	(or ()(0	ICTU	1	1)	170	6	)	1	2/12/2	00	
	3		30. Name and address werson w	no completed caus	e of death (Iter	т 23а) Туре,	Print)	71	1/107	tres	14/4	12	Has a	(77	. 4
	)		TONTAL CONTRACTOR	- Me	outy	(U1()	M		juryi	1100	T	C	11/100	VI Re	1/4
	Sta Registr		31. Date filed (Month, Day, Year)	32. H	egistrar's Sign	H A	wer						111	19130	5
DHM	H 17 Rev 1/2		DEC19	2005	Come de	a. Val.							WE	611	-
				4											

			FOR	ate of Marylar					ental Hy	giene	
			State Registrar		Cei	tificate	of Dea			Reg. No UU5	1269
	Physicia		1. Decedent's Name (First, Middle, Last) $Conray$	Sav	оу				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street		,	4b. City, Tov	. / -	on of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 11XM	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Y	Che Year If Universely Hou		8. Date of Birt (Month, Day Jan. 2 I	v. Year) Co	thplace (State or Foreign outry)
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	e Mary Ba-f eho	Director	Maryland Calve	rt		- ,	Leona	rd			1 ☐ Yes 2 🕅 No
	h with th	al Dire	10e. Street and Number 2360 Ross Road			10f. Zip Co	0685			10g. Citizen of What Co USA	ountry?
036	72 hours after death with the Maryland natural; or Items 23s or 28s-f ehow Jost Exactinat must be notified at	by Funeral	1 X Never Married 2 Married 1	/as Decedent Ever in U med Forces? □Yes 2∭No Yes, Give ear or Dates:	1	Was Decedent if Yes, specify 1 ☐ Yes 2 ☐	_		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whil Specify: B1 a	e, etc.
15-0	"natur	ieted	15. Decedent's Education (Specify only highest grade com	npleted)	16a. Dece	dent's Usual C kind of work of DO NOT use r	occupation done during r	nost of workin	ng	16b. Kind of Business	/Industry
212	il Hygiene. Chor than "	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)		borer	ourody			Constru	ction
Maryland 21215-0036	Q 22 D 9	To Be C	17. Father's Name (First, Middle, Last) $G1en$	Sa	voy			other's Name Lisa	(First, Middle,	Maiden Sumame) Butle	er
<b>Jary</b>	2 should and Men ie marke raumatic		19a. Informant's Name/Relationship (Турв, Р Lisa Savoy/Mother	rint)		ng Address (S				er, City or Town, State, .	
	Pages 1 and 3 ment of Health ant: if item 27 ury or other tr		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Remov	-14 01-1-	Place of Dispo	esition (Name of matory or othe UMC Ce	of or place)	l Da	ate 0/05	20c. Location - City or St. Leona	Town, State
Baltimore,	permit. Pages Department of Important: If I any injury or once.		14 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	le mell		2. Name and A		1			ome ed.,MD2067
1760,	hysician //Medical Examiner	icai Examiner	shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecut	uence of):	Accid	ent i	ith (	Compeli	cation	Interval Between Onset and Death
O. Box 68	death certificate e attending phy id for use as the	Physician/Medic	in the past 12 months?	yes, outcome of pregn □Live birth 2 □Feta □Pregnant at time of d □Unknown	aldeath 3[	⊒Ectopic pregr ∃Other (speci				23d. Date of de Month	livery Day Year
rds, P.	quires that n signed l	by	Part II. Other significant conditions contribu	ting to death but not res	sulting in the u	nderlying caus	se given in P	art I.		obacco use contribute to	
I Record	The law requires that the sate has been signed by the page 2 should be detache	Completed									utopsy findings available completion of cause of
Vital	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner?  1 es 2 No	tal: 1 Inpatient 2	] ER/Outpatier	27.004	Other		(Check only o	one) dence 6 □Other (Spe	aid d
of	ing Ph n. After th funeral	lion: To	27. Manner of Death 1 Natural 5 Pending	Ba. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c.	Injury at Work?	2	28d. Describe h	now injury occurred L	est
Division	Atten r deat ector: by the	Certification:	2 □ Could not be	Be. Place of Injury - At h building, etc. (Speci	iome, farm, str	reet, factory, o			City or Tox	Street and Number or R vn, State) will ba.	n whenf at
	To the Hospital or within 24 hours affer to the Funeral Dir. completely filled in a	Medical C	29a. Certifier 1 Certifying Physicial (Check only one) 2 Medical Examiner:	n: To the best of my kn On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at t vestigation, in	the time, date my opinion,	and place, a	and due to the	cause(s) and manner at date and place, and due	s stated. MAR had a to the cause(s)
	To th withir To th	Me	29b. Signature and fittle of certifier	Mestr	Do	1	icense numb			29d. Date signed (Moni	_
	3		30. Name and address of person who come le	eted cause of death (Ite	m 23a) (Type,	Print)	Drive	927 L	april	Mary 1	and
	Sta Regist		31. Date filed (Month, Day, Year) DEC - 7 2005	32. Registrar's Sign	ature				11		

			For	State of Ma							•		-	
			1 - State Registrar			Cei	tifica	te of L	Death			Reg. No	2005	1.1270
ľ	Physici	an	Decedent's Name (First, Middle, Last)								<ol><li>Date of De Month</li></ol>	Day		
	/Media	cal	Lucia Hawley St.  4a. Facility Name (If not institution, give:				4b Cib	, Town, or	I continu		Decemb	7		10:24 A.M
	Examir	ier	5535 Starkey Lane	street and number)				nce F					County of Dea	am
	Funeral		5. Social Security Number 6. Sex	_	e (In yrs. la	ast birthday)	If Und	er 1 Year	If Under		8. Date of Bir (Month, Da			rthplace (State or Foreign ountry)
	Director		578-18-5637	M 2XF 89		Yrs.	Months	Days	Hours					shington, DC
	and and		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary	to	Maryland Calvert		Prin	nce Fre	eder	ick						1 ☐ Yes 2 No
	72 hours after death with the Maryland naturel, or itema 23a or 28a-f ehow disal Exemisier must be notified at	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of What C	ountry?
	23a c		5535 Starkey Lane				20	678			ı	Jnit	ed Stat	es
	tema nerm	Funeral		12. Was Decedent 8 Armed Forces?		S. 13. \	Was Dec f Yes, sp	edent of His	spanic Orig n, Mexican	gin? (Spec n, Puerto F	cify Yes or No lican, etc.)	-	14. Race - Am Black, Wh	
36	irs aft	by F	1 Never Married 2 Married  Wildowed 4 Divorced	1 ☐ Yes 2√ N If Yes, Give Year or Dates:	NO		t □ Yes	No X	Specify:				Specify:	71
21215-0036	2 hou	ted	15. Decedent's Edu	cation		16a. Deced	lent's Us	ual Occupa	ition			16b. K	ind of Business	White S/Industry
218	within 7 ene. then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT	ork done d use retired)	uring mosi	t ot workin	g			
	e filed within al Hygiene. other then vent, the Ma		47 Fath de Alexa (Fine Middle ( and)	4		Secre	etar	У	10.11.11		(F)		Governi	nent
and	d be find be of ot	Be.	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Sumame)	
Maryland	should nd Men marke umatic	2	Jean Hawley  19a. Informant's Name/Relationship (Ty)	рө, Print)		19b. Mailin	a Addre	s (Street a		nie Me		ar. City o	r Town, State,	Zin Codel
	1 and 2 Health ar em 27 le		Thomas Starkey (Son	n)										land 20678
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-1 show many injury or other traumatic event, the Madical Exertical must be notified at DDGs.		20a. Method of Disposition		20b. Pla	ace of Dispo					ate		ocation - City o	
Ĕ	permit. Pages Department of I Important: If ite eny injury or of		1 ☐ Burial 2☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ropol	itan	Crem	atory	12/	5/2005	Ale	xandria	, Virginia
3a11	Depart Import eny in		21. Signature of Funeral Service License	Ĺ									l Home,	
	Or Cr E e of		Sty. 52										lic, Mary	rland 20676 Approximate
) Ac	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	- 1	nic	Obstr	odin	c /	Jamono	ny L	PISCRIE			Interval Between Onset and Death
o c	icate be executed physicien and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										
3760,	y s	cal												
.O. Box 68	The law requires that the death certifica ate hes been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic	pregnancy				1	23d. Date of de Month	livery Day Year
о.	s that gned b	by Pr	Part II. Other significant conditions con	tributing to death bu	ut not resul	lting in the ur	derlying	cause give	n in Part I.		23e. Did to	obacco u	se contribute t	o the cause of death?
ord	w requires t been signe should be	ted									1036	es 2[	□No 3□P	robably 4 🗍 Unknown
Vital Records,		Completed											prior to death?	utopsy findings available completion of cause of
Ž	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	005	R/Outpatien		Othe			(Check only o			
o	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injur	y :	28b. Time of	3 🗆 🗆	28c. Injury	at		e 5 Hesio		Other (Specy occurred	ecify)
Ö	Attending in death. ector: After by the fune	atlo	1.☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	м	Work 1 □ Y	? es 2 □ N	No				
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	iry - At hor :. (Specify)	me, farm, stre	eet, facto	ry, office	-	28	Bf. Location (S City or Tox	Street and vn. State	d Number or R	ural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)	ician: To the best of ler: On the basis of and manner stat	examination	rledge, death on and/or inv	estigatio	n, in my opi	inion, deat	d place, ar th occurre	at the time,	date and	place, and du	e to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	1-0			29	c. License					e signed (Mon.	Tenno.
,	_		1 None	1 male	2	)		DY	1616			1/00	center	7 500
d	RO		David J. Tardio, M					БЯ	Spi +	a 250	)U 671	Omor	oc Mar	wland 20600
	Sta		31 Date filed (Month Day Year)	32. Registra	S Signatu	ıre			Julu	E 23(	JU, SUI	LOHO.	is, Mar	λταπα ζάρας
	Registr	ar	DEC -	O ZUUS	CASUAR.	. K.	do	greet.						

			For Stete Registrer	State of Ma	arylan		artment of				giene Reg. No:	005	41271
			Decedent's Name (First, Middle, L.)	ast)						2. Date of Dea	ıth	V	3. Time of Death
	Physicia /Medic		Justus		Tra	acey			Þ	ec 12,	2005	Year	3:45am <sup>м</sup>
	Examin		4a. Facility Name (If not institution, g.				4b. City, Town,		of Death			unty of Death	n
			Cumberland Villa 5. Social Security Number 6.			last birthday)	Cumber If Under 1 Yea		24 Hrs.	8. Date of Birth	Alle	0.0:4	nplace (State or Foreign
	Funeral Director		217-18-8354	1 M 2 F	85	Yrs.	Months Days		Min.	Mar 13,	1920	ML	intry)
	0		Usual Residence of Decedent			y, Town or Lo	estion						10d. Inside City Limits
	shov	ō	MD Allega	nv	100. 01		erland						1 Ves 2 No
	the N 28a-f	rect	10e. Street and Number		<u> </u>		10f. Zip Code				10g. Citizen	of What Cou	untry?
	23a or	D E	1 Baltimore Stree	t				21502	2		Ų	JSA	
	ems series	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexicar	rigin? (Spec n, Puerto R	city Yes or No- lican, etc.)	14.	Race - Amer Black, White	
36	safte , or It		1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 □ MYes, Give Year or Dates:		1	1□ Yes Ž∏ No	Specify:	•		Sp	ecify:whit	·e
21215-0036	2 hour	Completed by	15. Decedent's	Education	Korea	16a. Dece	dent's Usual Occi					of Business/I	
<b>5</b> 12	thin 7.	nple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or :	5+)	life.	kind of work don DO NOT use retir	e auring mos ed)	st of workin			_	
7	filed with Hygiene. other thar ent, the M		12 17. Father's Name (First, Middle, Las			laborer	•	10 Math	ada Nama	(First, Middle,			Foundry
Maryland	should be filed within 72 hours atter death with the Maryland nd Menal Hygiene. In desked other than "natural", or items 23a or 28a-f show imartic event, it a Mardicul Ever in art must be notified at	Be c	Justus William							•		-	Tracey
ary	2 should be and Mental ls marked craumatic ev	To.	19a. Informant's Name/Relationship				ng Address (Stree			Route Numbe	r, City or To	own, State, Z	ip Code)
Š	and 2 ealth a n 27 is		Catherine Feaste	r daug	hter	P.O.	Box 777			Ridgel	ley		WV 26753
Baltimore,	- I i		20a. Method of Disposition 1 □ Burial 2 XCremation 3	☐Removal from State			sition (Name of matory or other pi		Da			ion - City or 1	
Ë	permit. Pag Department Important: I any injury c		'4 □ Donation 5 □ Other (Spec	rify)	Sca	7.5	neral Hom			2/13/2005	Cresa	aptown	MD MD
Ba	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lic	engele / /	11	/ 2	Name and Add Scarpe					D 04500	
			23a. Parti. Enter the disease, or co	mplications that caused	the deat	h. Do not ent	er the mode of dy	ginia Av <sub>ring,</sub> such as	/enue; s cardiac or	Cumberla respiratory are	and, M rest,	D 21502	Approximate
,	Physician		Immediate Cause (Final	/	ne. O NA		nton		iane				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as		-	C (a)	0,30	-twi				13917
	Examiner		Sequentially list conditions,	b									·
/	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	luence of):							
_	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	juence of):							
8760,	ate be e	cal		C d									
89	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	IF FEMALE:										
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3	Ectopic pregnan	су			23d	. Date of deli- Month	very Day Year
0.	that the der ed by the a detached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9∏Unknown	t time of d	leath 5L	Other (specify)						
Δ.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death	out not res	sulting) in the u	nderlying cause g	jivenzin Part I	I.	23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sign should be		Chrone	Obstruct	ine	tuli	norany	1)15	we	1 🗆 Y	'es 2□N	10 3 Pro	obably 4 Unknown
Vital Records,	aw 1s b	Completed					V			24a. Was a			opsy findings available ompletion of cause of
Œ.	The ate h page	Com					_			perfor		death?	2□ No '
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_		thos		(Check only or			
o	Phys this ral dii	.: To	1 Yes 2 No	28a. Date of Inju	ıry	ER/Outpaties 28b. Time o	f 28c. Inj	ury at		e 5 🗌 Resid 8d. Describe h			ify)
lon	Attending Phy r death. ector: After thi by the funeral of	atlor	1 Natural 5 Pending 2 Accident investigat	(Month, Da	ıy Year)	Injury	W	ork? ⊒Yes 2. □	]No				
Division	Attendi er death. rector; A by the fu	ertification;	3 Suicide 6 Could not determine		jury - At h	ome, farm, st	reet, factory, office	9	2	8f. Location (S City or Tow	Street and N m, State)	lumber or Ru	ral Route Number,
Ö	ital or irs afte ral Din led in I	0											
	To the Hospital or Atteno within 24 hours after death To the Funeral Director; completely filled in by the	edical		Physician: To the best aminer: On the basis of and manner st	of examina								
	To the within 2. To the complet	Mec	29b. Signature and title of certifier	and maillier si	A.		29c. Lice	nse number		2	29d. Date si	igned (Month	, Day, Year)
	- > - 0		•	Top	don		Do	0033	280		Dec	12,:	2005
	3		30. Name and address of person wh	o completed cause of	death (Iter	m 23a) (Type,	Print)						
	7		31. Sunil Guptav.M.	).	-1.0	625 k	Cent Aver	าue Cu	ımber	land Mi	2150	02	
	Sta Regista		31. Date ined (Month, 10ay, Year)	2005 32. Regist	ars Signa	ature	A						
DHM	/H 17 Rev 1/2		5EC 2 1	2005	1111	13. 1	ASTERNATION OF THE PARTY OF THE						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 37 Time M. Death Month Day Year **Physician** 5 AM 12005 orcto labone 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homa If Under 1 Year If Under 24 Hrs Months Days Hours Min. MORC orest Nursing 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 83 Months 1092094 393 1 ☑ M 2 ☐ F Malta Director 381-30-7411 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Counts item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at MD Cecil Port Deposit ¥ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 27 Birch Ct. U.S.A. Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or Itel 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White ð 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Postal service Postal 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Coroato Tabone Maria Cauchi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27 Birch Ct. Port Deposit, MD 21904 19a. Informant's Name/Relationship (Type, Print) Loreto Tabone (Son) Pages 1 and 2 ment of Health a ant: If item 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place)
R. A. Ferris & Co. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ō 12/19/05 West Chester, PA permit. Page Department of Important: If any injury or once. ` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 usien essel 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) J-7515 Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1858) of the light Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ě Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be F.NSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed

Examiner

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Be

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Certification:

Medical

in by the funeral director,

certificate

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After

after death.

within 24 hours a To the Funeral C

completely

2

To the Hospital or Attending Physician:

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner?

31. Date filed (Month, Day, Year)

1 Tes 2 No

27. Manne of Death

Natural

2 ☐ Accident

4 Thomicide

3 Suicide

29a. Certifier

NSUFFICIENCY

Date of Injury (Month, Day Year)

7220

Hospital:

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

24a. Was an

autopsy performed 2 No 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 Yes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

м

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier well.

5 Pending investigation

6 Could not be determined

29c. License number

29d, Date signed (Month, Day, Year)

State Registrar



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of Ma	ryland	-		ent of He ate of D		Me		giene leg. No.	alle alle on o	·
	_		Decedent's Name (First, Middle, I	ast)						2	. Date of Dea	th	< UU,	3. Time of Death
	Physici /Medic		BEATRICE TAPLIN							N	Month OVEMBE	R 29		3:55 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g					•	Location of Dea			4c.	County of Dea	
			HOLY CROSS HOSP  5. Social Security Number 6		(In vrs. las	st birthday)		SILVEI ler 1 Year	SPRIN If Under 24 H		. Date of Birth			GOMERY thplace (State or Foreign
	Funeral Director		125-07-8469	1 □ M 25€ F	86	Yrs.		s Days	Hours Mi	n.	(Month, Day EB 22,	Year)	C	W YORK
	p.		Usual Residence of Decedent			Town and a					== ==,			
	shov	ō	MD 10b. County MD MONTO	GOMERY	TOC. City,	Town or Lo	cation	STL	ER SPR	TNG				10d. Inside City Limits 1 X Yes 2 No
	28a-f	Director	10e. Street and Number				10f. 2	Zip Code				10a. Citi	zen of What C	
	h with	I D	515 APPLE GROVE	ROAD					20904				U.S	
	ems 2	Funeral	11. Marital Status	12. Was Decedent En	ver in U.S.	. 13. V	Was Dec	edent of His	spanic Origin? , Mexican, Pue	(Specif	fy Yes or No-		14. Race - Am Black, Whi	
3	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcal Examinan must be notified at	by Fu	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	D			2 X No	Specify:				Specify:	WHITE
5-0036	2 hour		15. Decedent's	Education	1	16a. Deced	lent's Us	sual Occupat	tion			16b. Ki	nd of Business	/industry
צות	within 72 ene. than "nat	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5+	-)	(Give lite. L	kind of v OO NOT	vork done du use retired)	uring most of w	rorking				
7		Con	12			C	FFI	CE MAN					FIRM	
Maryland		Be	17. Father's Name (First, Middle, La SAMUEL TAPLIN	st)					18. Mother's N LENA W			Maiden	Sumame)	
Ŝ	should nd Me mark mark	ပ	19a. Informant's Name/Relationship	(Type, Print)		19b. Maifin	ig Addre	ss (Street a				r, City o	Town, State,	Zip Code) 20008
Σ	alth ar		PHILIP N. TAPLIN	1/NEPHEW										NGTON DC
e G	of Ho		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3		20b. Pla	ce of Dispo	sition (N			Dat			cation - City or	
Baitimore,	tment tant: I		4 Donation 5 Other (Spe	city)	METE									, VIRGINIA
g	permit. Pages 1 and 2 should be Depertment of Health and Monta Important: If Item 27 Is marked any Injury of pather traumatic wore.		21. Signature of Funeral Service Lic	ensee Otottlan	nee	DA	Name NZAI	and Address NSKY-C	of Facility OLDBER	G M	EMORIA	L CH	APELS,	INC.
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused t	the death.	Do not ente	er the m	ode of dying	LLE PI	ac or r	espiratory arr	est,	MARY	AND 20852 Approximate Interval Between
,	Physician		fmmediate Cause (Final disease or condition	_a SEPSIS										Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):								
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. URINARY Due to (or as a			CTI	ON						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. ALZHEIME	R'S D	)EMENT	'ΤΔ							
Ď,	a exectan en urial-tr		resulting in death) Last	Due to (or as a										
09/80	licate be executed physician end s the burial-transit	edical	8	d. DIABETES	MELI	LITUS								
ROX	ding se es	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o								2	23d. Date of de	livery
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 XNo	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			Ectopic Other (	pregnancy specify)					Month	Day Year
J O	ires thet the de signed by the a be detached t	Phys	9 Unknown					ACC Velago	- 10 - 10 - 1		88. 644			
ds,	requires thet the een signed by th hould be detache	<u>م</u>	Part II. Other significant conditions	contributing to death but	t not result	ing in the ur	naenying	j cause give	nin Paπi.			es 2[		o the cause of death?
ecords,	> 4 5	lete									24a. Was a			
r	e le has	ompleted									autops perfor	sy med?	prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
VITā	ysician: Th is certificete director, peg	BeC	25. Was case referred to medical examiner?						26. Place of D	eath (0			1 10:	5 2 NO
٥ ا	W 10	10	1 ☐ Yes 2 🛣 No	Hospital: 12 Inpatien		R/Outpatien			4   Nursing	Home	5 ☐ Resid	ence (	0 ☐Other (Spe	ocify)
	on the	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	М	28c. Injury Work	at ? es 2 ∐ No	280	d. Describe h	ow injur	y occurred	
DIVISION	Attending r death.	flcat	2 Accident investigat 3 Suicide 6 Could not determine	t be 28e. Place of Injur	ry - At hom	ne, farm, stre			65 2 140	281				ural Route Number,
É	s after al Dire	Certification;	4 ☐ Homicide	building, etc.	(Specify)			•			City or Tow	n, State	)	
	To the Hospitel or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the ti	edical	29a. Certifier t\(\int\) Certifying (Check only one) 2  Medical Ex	Physician: To the best of aminer: On the basis of and manner state	exa <i>m</i> inatio	ledge, death on and/or inv	occurre estigation	ed at the time on, in my opi	e, date and pla inion, death oc	ce, and	d due to the c at the time, d	ause(s) late and	and manner a	s stated. e to the cause(s)
	To the within To the complé	Med	29b. Signature and title of certifier	C. C. Marillor State			2	9c. License	number		ż	9d. Dat	e signed (Mon	th, Day, Year)
L	12		10000	2 VC				D0062	520			NOV	EMBER 2	29, 2005
			30. Name and address of person wh				,		110					
	Sta	te	MARIA D ARBELA 1 31. Date filed (Month, Day, Year)						NG, MAI	KY LA	AND 20	910		
	Registr			2005 32 Registrar	, J.	100	de	,						

			For State Registrar	State of M	aryland /		rtmen tificate			and M	-	giene	UUD	41274	
	Physicia	an	1. Decedent's Name (First, Middle, Las	)							2. Date of De Month	Dav	y Year	3. Time of Death	
	/Medic	al	GARY L. TAYLOR  4a. Facility Name (If not institution, give	atroat and number			4h Cihr	Tour or	Location o	f Dooth	Decembe		2005 County of Dea	2:10 PM	<u>л</u>
	Examin	er	Wicomico Nursing					isbur		Dealli		46.	Wicomic		
	Funeral		5. Social Security Number 6. Se	x 7. Ag	je (în yrs. last bi	irthday)	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)		thplace (State or Foreignuntry)	gn
	Director		210-44-0000	ZM 2□ F	58	Yrs.	Morans	Duys	Tiodio		11-12-1	947	SAL	ISBURY, MD.	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation							10d. Inside City Limit	s
	Mary a-f sh	tor	MD WICOM	LCO	SALIS	BURY								1√2 Yes 2 □ N	0
	or 28.	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What Co	ountry?	
	s 23a	rail	1002 HERON COURT	45.11.	F	10.1	1		1804		-7 M N		USA		
	fter de	Fune	11. Marital Status  1 ☐ Never Married 2 ▼ Married	12. Was Decedent Armed Forces? 1 Yes 2		13. 1	Yes, spec	ent of His	n, Mexican	, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit		
3	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Evariliner must be rollined at	by	3 Widowed 4 Divorced	It Yes, Give Year or Dates:	1966-67	1	☐ Yes 2	2∏ No	Specify:				Specify: V	HITE	
21215-0036	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or Itams 23a or 28a-f show evant, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	168	(Give	lent's Usua kind of wor	k done d	urina most	of worki	ng	16b. K	ind of Business	/Industry	
7	withir ene. than	ошо	Elementary/Secondary (0-12)	College (1-4or			DO NOTUS L BUS			JER		SPC	RTING G	פתחחים	
	filed I Hygi other	Be C	17. Father's Name (First, Middle, Last)					11120			(First, Middle,			0000	
<u>Iar</u>		To B	BILLY BROWN TAYLO	2					BERN	NETTA	ANDER	SON			
Maryland	2 sho		19a. Informant's Name/Relationship (7										r Town, State, a		
	is 1 and 2 should of Health and Mer item 27 Is marks othar traumatic		CATHERINE R. TAYLO	DR - SPOUS	20b. Place	of Dispo	sition (Nam	ne of			BURY MA		ND 2180		
Baltimore,			1 XBurial 2 Cremation 3 : 4 Donation 5 Other (Specify			-	natory`or of T. MEM		1	12-06	-2005	HEBD	ON, MAR	VIAND	
<u>=</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens			22	. Name and	d Address	s of Facility	BOUN	DS FUN	ERAL	HOME,	INC.	
n	88 5 8		Sett L.	m	1	70	5 EAS	1 MA	IN ST	REET	, SALIS	BUKY	,MARYLA	ND 21804	
	Physician	-	shock, or heart fail re. Let only of immediate Cause (Final disease or condition	lications that caused the cause on each li	d the death. Do ne.	not ente	er the mode	e of dying	, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):									
	- L	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):	•								_
	outed id ansit	Examiner	that initiated events	C.											
/60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):									
$\infty$	cate b physic s the b	dical	•	d											_
Box 6	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of del	ivery	
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death t time of death		Ectopic pre Other (spe						Month	Day Year	
J.	hat the de id by the a detached t		9 ☐ Unknown  Part II. Other significant conditions co		nut not resulting	in the ur	nderlying ca	IISA TIVA	n in Part I		23e. Did to	obacco u	use contribute to	the cause of death?	
ecords,	uires that signed b	d by	0 .	OPFANOC	_		0	LSY				/es 2			n
Ç	w require s been sig should b	iete	HYPELTENSION								24a. Was		24b. Were at	topsy findings available	9
$\boldsymbol{\Upsilon}$	Physician: The lav this certificate has al director, page 2	Completed	PIABETES	MEG	TUS							sy rmed2 2√2 No		completion of cause of	
Vital	cian: ertifica ector,	Be	25. Was case referred to medical examiner?		700	197		104	-	- Section	(Check only o	ne)			
	Physi this c	2	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpation	ent 2 ER/O	utpatien Time of			4/ Nur		ne 5 Resid		6 Other (Spe	city)	
O	th. : After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	м	Bc. Injury Work 1 🔲 Y	?` 'es 2 🔲 N				,		
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Diractor: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	ury - At home, f	arm, stre	et, factory	, office		2	28f. Location (5 City or Tox	Street an	d Number or Ru	ıral Route Number,	
	urs aft rral Di		***************************************												_
	Hosp 24 ho Funs etely fi	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	vsician: To the best iner: On the basis of and manner st	it examination a	je, death nd/or inv	occurred a estigation,	in my op	e, date and inion, deat	d place, a th occurre	and due to the order at the time, or	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor; After th completely filled in by the funeral	Me	29b. Signature and title of certifier				-	. License				29d. Dat	e signed (Monta	h, Day, Year)	
	2 50		Mulust	NT	MD	)	1	1-00	1603	15		/	12/1/	15	
	The B		30. Name and address of person who o					2 -1	0400	\ t.			1.1		
	Sta	to:	Maesha Thimmarayappa 31. Date filed (Month, Day, Year)		asternshorar's Signature	ore D	r Sal	1 Sbur	y 2180	)4					
1.0	Registr		DEC 0 5 2		yes It.		MARKE	Ģ							

,8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brouns attend death.  On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Medical Certification: To Be Completed by Physician/Medical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ACUTE RENAL FAILURE  Due to (or as a consequence of):  SEPSIS
Division of Vital Records, P.O. Box 68760	The law requires that the death certificate be cate has been signed by the attending physicial page 2 should be detached for use as the bur Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Other 9 ☐ Unknown
ords, P	v requires that been signed b should be deta	PERIPHERAL ARTE	
Vital Rec	secian: The lav certificate has irector, page 2.	CORONARY ARTERY  CONGESTIVE HEAR  25. Was case referred to medical examiner?  1 □ Yes 2√√ No	RT FAILURE
ision of	Attending Physical death.  ctor: After this c y the funeral direflication: To	27 Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Alter t completely filled in by the funeral Medical Certification:	29a. Certifier 1X Certifying (Check only one)	building, etc. (Specify)  Physician: To the best of my knowledge, death occur  caminer: On the basis of examination and/or investigated and manner stated.
O R	2 (3)	29b. Signature and title of certifier  Patricula  30. Name and address of person wf  PATRICIA EBEN M	the completed cause of death (Item 23a) (Type, Print)  MD, 3001 Hospital Drive (
	State Registrar	31. Date filed (Month, Day, Year)  DEC 0 6 201	2. Registrar's Signature
DHA	4H 17 Rev 1/2001		ORIGINAL

	1- For State of Mary Registrar		rtificate of L			eg. No.	UO	41215
\$6°	Decedent's Name (First, Middle, Last)				2. Date of Oea Month	th Day	Year	3. Time of Death
ical	CHARLES L.		CHOMAS		NOVEMBE	28, 2	005 2	120 <sup>M</sup>
iner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County		O.F.
- 35	PRINCE GEORGE HOSPITAL  5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	CHEVERLY  If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	)	E GEOR	
3	217-28-1727 1XM 2□F 72	Ven	Months Days	Hours Min.	(Month, Day 12-23-19	, Yea <i>r)</i> 932	SOUTH	ce (State or Foreign CAROLINA
	Usual Residence of Decedent	c. City, Town or Lo	ecation					. Inside City Limits
5		ZATTSVILI					100	1X Yes 2 No
Funeral Director	10e. Street and Number		10f. Zip Code		1	Og. Citizen of	What Country	r?
D	5108 KENILWORTH AVENUE #5		20781			U.S.		
nerg	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No-	14. Rac	e - American	
	1 Never Married 2 Marned 1 Yes 2 No A	ARMY	1 ☐ Yes 2 📉 No	Specify:			v: BLAC	
Completed by	3 ☐ Widowed 4 ☼ Divorced Year or Dates:	16a Dece	dent's Usual Occupa	ition		16b. Kind of B	usiness/Indus	stry
piet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done a DO NOT use retired,	uring most of wor	king	100. 14110 0. 0	201110000111000	,,
l e	12th	N	MAIL CARRI	ER		GOVE	RNMENT	
Be	17. Father's Name (First, Middle, Last)		and the second s		ne (First, Middle, i	Maiden Suman	ne)	
10	CHARLIE LEE THOMAS  19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Address (Street a	LEOLA TH		City or Tour	State Zin Co	a do l
	TAJUANA R. JACKSON/GODDAUGHTH		ANAIO CT			-	State, Zip Co	300)
		0b. Place of Dispo	sition (Name of natory or other place		Date	20c. Location	City or Town	, State
	1 ☐ Burial 2 🌣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		CREMATOR		0-2005 I	RIVERDA	LE, MD	
	21. Signature of Funeral Service Licensee		2. Name and Addres		JENKINS			Е
	23a. Part1. Enter the dise se, or complications that caused the shock, or heart failur. List only one cause on each line.						A	pproximate
	Immediate Cause (Final disease or condition DILATED (						Ö	terval Between inset and Death
	resulting in death)  a. Due to (or as a col		ALIII					
	Sequentially list conditions, if any, leading to immediate							
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that injurised events.)  ACUTE REN		IDE				ļ	
Examiner	that initiated events resulting in death) Last C. ACCIE REP		IKL					
edical	d. SEPSIS							
	IF FEMALE:							
Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)				te of delivery onth Da	ay Year
hysic	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	, or double						
y P	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	in in Part I.	23e. Did to	bacco use cont	ribute to the	cause of death?
ted	PERIPHERAL ARTERIAL DISEASE				1 🗆 Y	es 2□No	3 Probab	ly 4\(\frac{1}{2}\)Unknown
npie	CORONARY ARTERY DISEASE				24a. Was a autops	SV	Were autopsy prior to comp	findings available letion of cause of
ပ်	CONGESTIVE HEART FAILURE				1 Yes		death? 1 ☐ Yes 2[	□No
o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient	2 ER/Outpatier	nt 3 DOA Othe		th (Check only on ome 5 - Reside		(0 1)	
Ë	27. Manner of Death 28a. Date of Injury			at	28d. Describe ho			
atio	2 Accident investigation	an milaty		es 2 □No				
ertific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rural R	oute Number,
Medical Certification: To	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my one to make the control of the pasts of examiner: On the basis of examiner stated.	y knowledge, deatl mination and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place,	anner as state and due to th	ed. e cause(s)
Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date signe	d (Month, Da	y, Year)
	Patrice Gise 1	1D	DAD	57631	5	11/20	1/20	05
	30. Name and address of person who completed cause of death		Print)			· · · · · · · · · · · · · · · · · · ·		
tate	PATRICIA EBEN MD, 3001 Hosp 3	ital Driv		Y, MD 20	1/85			

333	2	OIN .	Please To Please							Are Legible.	
			Registrar  1. Decedent's Name (First, Middle, Last)	Ja, 27, 20a	I per	Certifica	ate of D	eath	2. Date of Dea	0 0 0	3. Time of Death
	Physici /Medic	al	_	olleen	Tilsor		it. Tour or l	ocation of Death	DECEMBE		0800 A M
	Examin	er	409 GREENE STREET	reet and number)			íBERLAN	_	1	ALLEGANY	tn
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age	(In yrs. last bir 9		der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jul 14,	1976 9. Bir	thplace (State or Foreign buntry) MD
	ow EL		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow						10d. Inside City Limits
	a-feh	ctor	MD Allegany	/	C	umberla	and				1 ∑Yes 2 □ No
	with the	Funeral Director	10e. Street and Number			10f.	Zip Code	1502		10g. Citizen of What Co USA	ountry?
	death me 234	erai	409 Greene Street	2. Was Decedent Ev	er in U.S.	13. Was De			pecify Yes or No- o Rican, etc.)	14. Race - Ame	
036	urs after o al', or Ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			V	Mexican, Puerti Specify:	o Rican, etc.)	Specify: Wh	
2-0	72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade		16a.	Decedent's U	sual Occupati work done du	on ring most of wor	king	16b. Kind of Business	/Industry
2	within ene. then	ompi	Elementary/Secondary (0·12)	College (1-4or 5+	)	memak			i	Own Home	
ם 2	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)		11.10	moman			ne (First, Middle,	Maiden Sumame)	
<u>yla</u>	ould b Ments narked	5	Howard L. Jeffers						Boyle) Mo		
, Maryland 21215-0036	end 2 sh ealth and m 27 le m ner traum		19a. Informant's Name/Relationship (Typ. Lynn McMillan	mothe	er 3	326 Balt	timore /	d Number of Ru Avenue	Cumb		ID 21502
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Examinar motal be notified at once.		20a. Method of Disposition  1	emoval from State	cemete	f Disposition (I ry, crematory of er and Pa	or other place)		12/16/2005	Cumberlar	
Ball	permit Depart Import any inj	v	21. Signature of Funeral Service License	A1111	1.			of Facility Funeral H		9 8980 8	
			23a. Pant/ E ter the disease, or complices to ck, heart failure. List only on	calions that caused the	he death. Do					land, MD 2150 est,	Approximate Interval Between
200	Physician		Immediate Cause (Final disease or condition	Narcotic							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a							,
		e	Sequentially list conditions, if any, leading to infinediate	Due to (or as a	nonsaquence	of):					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	te be executed ysicien and ie burial-transit	<u>ag</u>	resulting in death) Last	Due to (or as a	consequence	of):					
Box 687	ertifica ling ph e as th	Med	IF FEMALE:								
D. Bo	es thet the death certificate igned by the attending phys be detached for use as the	by Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 W Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopid 5 □ Other	c pregnancy (specify)			23d. Date of de Month	livery Day Year
, P.O.	thet the	Y Ph	Part II. Other significant conditions con	tributing to death but	not resulting in	n the underlyin	ig cause given	in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	w requires the been signed should be de								1 🗆 Y	es 2⊡No 3⊡P	robably 4 🛣 Unknown
900	ne law re has bee ge 2 sho	Completed							24a. Was a		utopsy findings available completion of cause of
<u> </u>	: The cete h : page	Con							perfor 1 💢 Yes	med? death?	2 □ No
<u> </u>	Physician: The la r this certificete has nal director, page 2	To Be	25. Was case referred to medical examiner?  1 XYes 2 No	ospital:	t 2∏ER/Ou	itnationt 3	Other		th Check only or	ence 6 <b>X</b> Other (Spe	SCENE
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours date death.  To the Funeral Director: After this cartificate has been signed by th completely filled in by the funeral director, page 2 should be detached.	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Found, Day 12-10-05	28b.	Time of	28c. Injury a Work?			ow injury occurred	unk
Vis	r Atte	tifica	3 ☐ Suicide 6 🕻 Could not be 4 ☐ Homicide	28e. Place of Injur	y - At home, fa		tory, office		28f. Location (S City or Tow	treet and Number or R	ural Route Number,
	oltal o urs aft sral Di			Found at	reside				Cumberla	and, Maryla	and
	Hoel 24 ho Fundant	edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	er: On the basis of e and manner state	examination an	e, death occurr nd/or investigat	tion, in my opir	, date and place nion, death occu	rred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c. License r		1	29d. Date signed (Mon	
			I him him	mis			OCM	E 	I	DECEMBER 11	, 2005
			30. Name and address of person who co	mpleted cause of dea			STREET	. BALTTN	ORE. MAR	RYLAND, 212	.01
	Sta		31. Date filed (Month, Day, Year)	32 Registrar		A AMERICA			THE CLIPS	كلك وللاستست	io t
DH	Regist		DEC 1 9 200	Marie	JA.	grand	<u> </u>				
יחי	MH 17 Rev 1/2	.001			C	RIGINAL					

			1- State of Mary	land / Depa		lealth and N	lental Hygi	•	41277
	Dharaisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		STEPHEN TIMKO				DECEMB	ER 13 20	05 4:30a <sup>м</sup>
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Dea	th
			Chester River Hospital (		Chester	rtown	O Data of Dish	Kent	
	Funeral Director		5. Social Security Number 222-10-5499  Usual Residence of Decedent  7. Age (In 9)  Usual Residence of Decedent	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 30	1914 Per	thplace (State or Foreign ountry) nnsylvania
	yland 10w			c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar st	to	MD Kent F	Kennedy	ville				1X Yes 2 No
	or 28	Oire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath w	rail	11784 Augustine Herman H		21645			J.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. dothar than "natural", or items 23e or 28e-f show orthar than "natural", or items 23e or 28e-f show evant, the Medical Examinar must be indiffed at	y Funerai Director	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  12. Was Decedent Ever Armed Forces?  1 ☒ Yes 2 □ No II Yes, Give W		Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	hours ural',	d by	3 Wildowed 4 Divorced Year or Dates:	****					
7	n 72 "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work d)	ring	6b. Kind of Business. Chemical	-
12	within lene. than "	E C	Elementary/Secondary (0-12) College (1-4or 5+)		ctrician			Manufact	
b	should be filed and Mental Hygis marked othar matic evant, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (Fîrst, Middle, M		
lar	ouid be t Mental I arked o atic eva	To B	Michael Timko			Mary H	etz		
Maryland	2 8 9 10		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State, a	Zip Code) 21645
	an eali		Virginia Timko (wife)						edyville M
nore	5		117 Burial C Committee 2 Demouslifrom State		matory`or other plac	ce)		0c. Location - City or	Town, State
Baltimore,	pe mit. Page Department of Imcortant: if any injury or on:		21. Slave ore of Fun ral Servi Line (see	G <sup>2</sup>	2. Name and Address alena Fu	ss of Facility Ineral H	ome of	Stephen	L Schaech
	70 = e 0		MOO	510 11	l8 West	Cross S	t. Gale	na, MD.	21635 Approximate
la.	Physician		23a Part Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition		Control mode or dyin		or respiratory arre	st,	Interval Between Onset and Death
	/Medical Examiner		Due to (or ma a co	ensequence of):					r.
	LAdilille	_	Sequentially list conditions,	sclenti	e Lovor	any and	sery di	Scare	che
7	hed nslt	Examiner	Sequentially list conditions, it any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events	ribequarios orj.		1	1		-
<b>V</b>	be executed sician and burial-transIt	xan	that initiated events c	nsequence of):					
760,	te be executed ysician and se burial-transit	cai	d						
89			V						
Вох	death certifica e attending ph d for use as th	N/UE	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		DEctopic pregnancy			23d. Date of de	
	e deal he att	Physician/Med	1 Yes 2 No		Other (specify)		-	Month	Day Year
P.0	that the de ed by the a detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but no	at soculting in the co	andoch inn nouse ann	en in Doet I	23a Did tahi	acco use contribute to	the eques of death?
Š,	The law requires that the ste has been signed by the bage 2 should be detached.	by	CO ( O	ot resulting in the u	inderlying cause give	en in Part I.	239. Did (00.	<b>\</b>	robably 4 Unknown
0.00	w requ	etec							
Records,	has by	Completed					24a. Was an autopsy perform	prior to	stopsy findings available completion of cause of
a			OF IMP				1 ☐ Yes 2	No 1 Yes	20 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes No Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Othe	er	h (Check only one		alf-d
of	Phy or this oral d	-	27. Manner of Death 28a. Date of Injury	28b. Time o			28d. Describe how	nce 6 Other (Spe v injury occurred	city)
on	ath. r: After e funer	ation	Natural 5 ☐ Pending (Month, Day Ye	ar) Injury		k? Yes 2 ☐ No			
Division	Il or Attending after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury-building, etc. (S	At home, farm, str	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru	ural Route Number,
Ö	s afte	Certification	Dullaring, etc. (5	pocity)			Only of Town,	o.a.o,	
	To the Hospital or within 24 hours afte To tha Funeral Dis completely filled in	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of m 2 ☐ Medical Examiner: On the basis of examiner stated.	y knowledge, deat mination and/or in	h occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Mont	
			We We		5,	51735		12 / 14h	5
	44		30. Name and address of person who completed cause of death		·	Made C:	0-1	- WD 0	1625
	Sta	ite	Frederick Delboy, M.D.  31. Date filed (Month, Day, Year)  32. Paistrar's		North	main St	• Galen	a, MD. 2	1032
	Registr	-	EFO 1	B. A.	both				

			For State Registrar	State of Marylan		artment of H			Reg. No.	105	41279
	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	GYear_	3. Time of Death
	/Medic		Yvonne Tanner Tu					15			1546 M
	Examin	er	4a. Facility Name (If not institution, give str			4b. City, Town, or				ounty of Death	
	16.	S.	Calvert Memorial Ho  5. Social Security Number 6. Sex	Spital 7. Age (In yrs. I	act hirthday)	Prince F	If Under 24 h			alvert	place (State or Foreign
	Funeral Director			4 2½ F 66	Yrs.	Months Days		oct. 2	6, 193	39 Okla	ntry)  homa
	e Maryland ta-f show	ctor	10a. State 10b. County  Maryland St. Mary		r, Town or Lo ifornia						10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	23a	rai	2008 Wildewood Cent			20619				1 State	
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event. Its Medical Examination must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 🌠 No	ispanic Origin? in, Mexican, Pi Specify:	(Specify Yes or No uerto Rican, etc.)		Race - Ameri Black, White, pec <i>ify:</i> Whi	etc.
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Educa (Specify only highest grade : Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind	of Business/Ir	ndustry
	filed wi Hygien other th	S	12		Gover	nment Civ			USA		
Maryland	should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last)  James Luke Tanner					Name (First, Middle Susie Ho		ımamə)	
Mary	nd 2 sho alth and h 27 is ma r trauma	ľ	19a. Informant's Name/Relationship (Type Terrence Tucker (So			-		#163, Ca			
Baltimore,	Pages 1 and 3 nent of Health int: If Item 27 iry or other tra		20a. Method of Disposition 1 ☐ Burial ★☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of matory or other place		Date 2/5/2005		tion - City or T	
Baitil	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee		22	2. Name and Addre	ss of Facility	Rausch Fu Road, Port 1	neral	Home,	P.A.
,	Physician /Medical		23a. Part 1. Enter the disease, or complications, or heart failure. List only one timmediate Cause (Final disease or condition esulting in death)	cause on each line.							Approximate Interval Between Onset and Death
8760,	ate be executed by the burial-transit and the	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	dium o	di FR	ule a	ou th	. 2	
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1   Live birth 2   Fetal 4   Pregnant at time of do 9   Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	,		230	d. Date of deliving Month	rery Day Year
	uires that t n signed by Id be detac	þ	Part II. Other significant conditions conti	nbuting to death but not resi	ulting in the u	nderlying cause giv	en in Part I.			_	the cause of death?
I Records,	The law requir ate has been si page 2 should I	Completed						24a. Was auto peri 1 🗆 Yes	opsy ormed?	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Vital	stan: entific	Be	25. Was case referred to medical examiner?					Death (Check only	опе)		
	ng Physician: fter this certifica ineral director, I	၉	1 Yes 2 10 Ho  27. Manner of Death 1 Natural 5 Pending	spital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	y at	28d. Describe			fy)
Division of	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At houlding, etc. (Specification)	ome, farm, str		Yes 2 No		(Street and Nown, State)	Number or Rui	al Route Number,
	Hospitel or 24 hours afte Funerel Dir stely filled in	edicai Ce	29a. Certifier (Check only one)  Certifying Physical Examine	cian: To the best of my kno or: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	me, date and pi pinion, death o	lace, and due to the	cause(s) an	nd manner as a	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of confifier	and mainer stated.		29c. Licens	39 C	22	29d. Date s	signed (Month)	Day, Year)
	97		30. Name and address of person who con		23a) (Type,	Print)	From	22 buck	Mar	2 260	- <del>-</del>
A. A.	Sta Registi		31. Date filed (Month, Day, Year) DEC - 6	32. Registran Signal	ture	South	,		7011-		4

		1 - State Registrar		C	ertificate of		Rag. I	2005	41281
Physicia		Decedent's Name (First, Middle, La		Ronald We	eller		2. Date of Death December	13, <sup>2</sup> 20	3. Time of Death 05 07:20 a M
/Medica Examine		4a. Facility Name (If not institution, giv		1101101101		or Location of Death		4c. County of Dea	
		220 Summit Aven			Hagers			Washin	gton
neral ector		5. Social Security Number 6. S  220-42-5681  Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last birthd 60 Yrs	Months   Dave	s Hours Min.	8. Date of Birth (Month, Day, Yea February	1945 <sup>9. Bi</sup>	rthplace (State or Foreign Jountry) Saryland
item 27 is marked other than 'natural, or items 23s of 28s-1 show other traumatic event, the Madical Examinar must be notified at		10a. State 10b. County		10c. City, Town o	r Location			-	10d. Inside City Limits
	Director	Maryland Washing	ton		Hagers				1 XYes 2 No
		10e. Street and Number			10f. Zip Code			Citizen of What C	ountry?
ľ	Funeral	105 Fair Groun  11. Marital Status	12. Was Decedent	Ever in U.S.	2 17  13. Was Decedent of	40 Hispanic Origin? (Speciban, Mexican, Puerto F		U.S.A. 14. Race - Am	
,	Ī	1 Never Married 2 Married	Armed Forces?  1 Yes 2 X	No	If Yes, specify Cu		tican, etc.)	Black, Wh	ite, etc.
:	d by	3 Widowed 4 Divorced	Year or Dates:				1		White
1	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(G	ecedent's Usual Occi live kind of work don- le. DO NOT use retir	upation e d <i>uri</i> ng most of workin red)	g 16b.	Kind of Business	s/Industry
	E	Elementary/Secondary (0-12)  11	College (1-4or	5+)	Roofing			Construc	ction
1	Bec	17. Father's Name (First, Middle, Last	)			18. Mother's Name	(First, Middle, Maid	en Surname)	
	္	Milton E. Well					V. Calla		
		19a. informant's Name/Relationship ( Angela J. McInti.			_	et and Number or Rural Dund Ave. H			•
1		20a. Method of Disposition	re (baugi	20b. Place of Di	sposition (Name of	Da	ate 20c.	Location - City o	
		1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			crematory or other pl arg Cremat	Decem	ber 16, 05 Sm	ithsburo	Maryland
g		21. Signature of Funeral Service Lice			22. Name and Add		J.L. Dav		
Suc		Jan la	- Davis			dbury Ave.		rg, Mary	land 21783
ana		23a Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition				ying, such as cardiac or ovascular d			Approximate Interval Between Onset and Death
cal ner		resulting in death)	a	a consequence of):					
4	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	а вопвединген об):					
1	amlner	that initiated events	c						
di	ŭ	resulting in death) Last	Due to (or as	a consequence of):					1
ŗ	dica		d.						
	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	alivon
	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)			Month	Day Year
ľ	ΣP	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause g	given in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
:	ed	Chronic alcohol	abuse, dia	betes mel	litus		1 🗆 Yes	2□No 3□P	robably 4 Unknown
	pie						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	် မ						performed?		
	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death			
,	: <u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b. Tim	e of 28c. Inj	4   Nuising non	ne 5 Residence 8d. Describe how in		ecity) SCENE
	ō	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Inju		ork? □Yes 2□No			-
	at	3 Suicide 6 Could not be determined	28e. Place of in	ury - At home, farm, c. (Specify)	, street, factory, office	9 2	8f. Location (Street City or Town, Str		lural Route Number,
	tificat	4 Homicide determined							
	Certification: To	4 Homicide			eath occurred at the	time, date and place, a	nd due to the cause	(s) and manner a	s stated.
		29a. Certifier 1 Certifying Pl	minar: On the basis of	f examination and/o	r investigation, in my	opinion, death occurre	d at the time, date a	and place, and du	e to the cause(s)
	Medicai Certificat	29a. Certifier 1 Certifying Pl	hysician: To the best minar: On the basis of and manner st	f examination and/o	r investigation, in my	opinion, death occurre		and place, and du  Date signed (Mon	e to the cause(s)
		29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	minar: On the basis of	f examination and/o	r investigation, in my	nse number	29d. I	Date signed (Mon	e to the cause(s)
completely tilled in by the funeral		29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	minar: On the basis of and manner st	if examination and/o	r investigation, in my		29d. I		e to the cause(s)
		29a. Certifier (Check only one)  29b. Signature and title of certifier	minar: On the basis of and manner st	f examination and/o ated. death (Item 23a) (Ty	29c. Licer	nse number	29d. t	Date signed (Mon	e to the cause(s)  oth, Day, Year)  4, 2005

			For State State Registrar	of Maryland	•	rtment of H		Mental Hy	giene Reg. No. 2005	41282
			Decedent's Name (First, Middle, Last)					2. Date of De	eath Day Year	3. Time of Death
	Physicia /Medic		CHARLES HENRY WILK	INS				12	01 2005	14:44 PM
	Examin		ta. Facility Name (If not institution, give street and		,	4b. City, Town, or	Location of Dea	th	4c. County of Dea	
			Peninsula Legional N.		rter	If Under 1 Year	If Under 24 Hr	S Date of Bi	Wicom	
	Funeral	İ	5. Social Security Number 6. Sex	7. Age (In yrs. last	Yrs.	Months Days	Hours Min	. (Month, Da	ay, Year) 9. Br 27, 1941 Ma	thplace (State or Foreign ountry)
	Director	}	Usual Residence of Decedent					sept.	21, 1941 Ma	ryrand
	yland		10a. State 10b. County	10c. City, T	own or Loc	ation				10d. Inside City Limits
	Be-f.	Funeral Director	MD Worcester	Pocom	oke C	ity				1 ☐ Yes 2 ☐ XNo
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath w	ral	3913 Whitesburg Road			21851			USA	2
	er de Item	nue	Armed	ecedent Ever in U.S. Forces? s 2 2000	13. V	as Decedent of Hi Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	nto Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	If Yes,	Give or Dates:	1	□Yes 2🏞No	Specify:		Specify: W	hite
Õ	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28e-f show he Modical Examiner must be notified at	ted	15. Decedent's Education			ent's Usual Occupa			16b. Kind of Business	/Industry
215	hin 7:	ple	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	life. C	kind of work done a OO NOT use retired,	luring most of we	orking		
21,	ge wit	Completed	12 8		Far	mer			Agricult	ure
Maryland 21215-0036	d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
<u>8</u>	ould I Men Men arke	<sup>1</sup>	William Henry Wilkin	-				Merril		
Ja Ja	2 sh and ls m		19a. Informant's Name/Relationship (Type, Print)	1					er, City or Town, State,	
9			Gloria Wilkins (wife) 20a. Method of Disposition			Whitesbu	rg Ra.,	POCOMOK Date	e City, MD  20c. Location - City or	
Baltimore.	Trofi		1⊠ Burial 2 ☐ Cremation 3 ☐ Removal fr	om State cem	etery, crem	atory or other place	·			
Ē	rtmer rtant njury	14	4 □ Donation 5 □ Other (Specify)  21. Signature of Fymeral Service Licensee	FIISU		st Cemetery			Pocomoke C	TCA, MD
B	Dep June		Mil O The		HC	olloway M	elson F	uneral H	ome, P.A.	1051
			23a. Part1. Enter the disease, or complications th	at caused the death. I					City, MD 2	Approximate
	Dhysisian		shock, or heart failure. List only one cause of immediate Cause (Final		1 6-0	T. 0.	+			Interval Between Onset and Death
ч	Physician /Medical		disease or condition resulting in death)  a	Nyocard to (dras a consequen	nce of):	Lhta	relioi			nours
ş .	Examiner			PYOU AL	ru	Arter	9 Di	sedse		Years
20		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	to (or as a consequen	ice of)	•	1			1
7	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Athero		20051	S			years
, o	e exe cian a urial-		resulting in death) Last Due	to (or as a consequen	nce of):					•
(2 - 8760	ate b	dical	d							
* 68	death certificat e attending phy d for use as th	/Me	IF FEMALE: 230 If yes	outcome of pregnancy	,		11.00		201.00.41	
213. Box	attend for us	ian	in the past 12 months?	ve birth 2 Fetal de egnant at time of deatl	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
0	0 0 2	ysic		nknown	., 3	Curer (speciny)				
25.	£ 90 p	g.	Part II. Other significant conditions contributing	o death but not resultir	ng in the ur	derlying cause give	en in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
Kin rds.	quires n sign	g p	Hyperlipido	mia				10	Yes 2ŪZNo 3□P	robably 4 Unknown
7.		Jete	/ 1					24a. Was	an 24b. Were a	utopsy findings available
3 8	: The law cate has t , page 2 s	Completed by Physician/Med						auto perfe		completion of cause of
es Vital	Ician: Th certificate ector, pag	0	25. Was case referred to medical				26. Place of De	eath Check only		200
/es	S S E	To B	examiner? 1 Yes 2 No Hospital: 1	☑npatient 2□ER	VOutpatien	3□ DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Res	idence 6 Other (Spe	ecify)
ari	Jing Pt J. After th funeral		27. Manner of Death 28a. D. 1 ☐ Natural 5 ☐ Pending	ate of Injury 28 Nonth, Day Year)	Bb. Time of Injury	28c. Injury Work	at c?	28d. Describe	how injury occurred	
Cha Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation				Yes 2□No			
N N	or Att	E	4 Homicide determined 28e. P	ace of Injury - At home uilding, etc. (Specify)	e, farm, stre	eet, factory, office			'Street and Number or R wn, State)	ural Route Number,
	Hospitei or Attenv 24 hours effer deatl Funeral Director: tely filled in by the		29a. Certifier 1 Certifying Physicien: To	the best of my knowle	das dost	accurred at the term	a data and play	no and due to the	course(s) and manner s	o atota d
	Hos 24 hc Fun stely	edicai	(Check only 2 Medical Examiner: On the	e basis of examination nanner stated.	and/or inv	estigation, in my op	pinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
	To the Hospitel or Attending Ph within 24 hours efter death To the Funeral Directors. After th completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	th, Day, Year)
	- S - O		> Xabtha	_		03	3678	3	12/03	105
			30. Name and address of person who completed of	ause of death (Item 23	3a) (Type,	Print)			, 5	1010:
C,	H. 10		Jeffrey Ethe	cause of death (Item 23	-0-	PRM	IC S	SALTS134	Ry, mo.	21801
	Sta		31. Date filed (Month, Day, Year) 3  NFC 0 5 2005	2. Fegistrar's Signatur	1	ante			,	
	, Registr	ar	DEC 0.9 5003	MERCHAN N	19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 5 For State Registra Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DECEMBER 1, LEONARD WINNICK 2005 7:50P /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner POTOMAC VALLEY NURSING HOME ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 12/7/1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 ★M 2 F 77 578-30-9205 PA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in then "natural", or Iteme 23a or 28a-f show the Medical Exeminer must be notified at 1 XYes 2 ☐ No Completed by Funeral Director MD MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 OLD CREEK COURT 20854 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No WHITE Specify: Specify: If Yas, Give Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 INSURANCE BROKER rment of Health and Mental Hyg-tant: If item 27 is marked other lury or other traumatic event, the SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY WINNICK BERTHA HIRSCHBLOND 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANNE WINNICK/WIFE 22 OLD CREEK CT, POTOMAC, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or of Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS DEC 5, 2005 OLNEY, MARYLAND 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Finat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine nding physician and use as the burial-transit m(e that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of deliver 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by certificate 25 Be 2 After thi funeral 27. Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. within 24 hours after death. To the Funeral Director: A Director: filled in by

Baltimore, Maryland 21215-0036

		1 🗆 Yes	s 2 No 3 Probably 4 Nunknown
		24a. Was an autopsy perform	prior to completion of cause of
25. Was case referred to medical		26. Place of Death (Check only one	)
examiner? 1 ☐ Yes 2 No	Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA	other: 4 Nursing Home 5 - Resider	nce 6 Other (Specify)
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation			
3 Suicide 6 Could not to determined		e 28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	hysici n: To the best of my knowledge, death occurred at the miner: On the basis of examination and/or investigation, in my		

of certifie

29b. Signature and

D0062435

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYEID EISAYYAID 9715 Kockui'lle - Medicocaler Dr. 9715

31. Date filed (Month, Day, Year) 32 Registrar's Signature 06 DEC



State

Registrar

			1 - State Registrar	State of M	Marylar	•	artmen <i>rtificate</i>				,	giene	005	41285	
n And	Physici /Medi		1. Decedent's Name (First, Middle, La	st) Marion	Wh	ite					Date of Dea Month	ath Day	Year	3. Time of Death 4:14 PM	
	Examir		4a. Facility Name (If not institution, gives SALISBURY REHAB & 5. Social Security Number 6. S	NURSING	CENTE	ER . last birthday)	SALIS If Under	BURY 1 Year	If Under	2180	)4 B. Date of Birt	WIC	OMTCO 9. Birth	place (State or Foreign	
7-	▶ Director		216-40-4575  Usual Residence of Decedent  10a. State 10b. County	<b>⅓</b> M 2□F	65	Yrs.	Months	Days	Hours	Min. 8	Date of Birt (Month, Date) 3/27/19	940 940	Mary	land  10d. Inside City Limits	
	r 28a-f ehe	Irector	Maryland Wicom  10e. Street and Number	ico		Salisb	ury 10f. Zip	Code				10g. Citizen	of What Cou	X☐Yes 2☐No	
036	within 72 hours after deeth with the Maryland ene. than "natural", or Itams 23s or 28s-1 show to Medical Exercitar mat be notified at	by Funeral Director	200 Civic Ave.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date		rfy Cubar	spanic Ori	gin? (Specr n, Puerto Ri	can, etc.) Black, Wh			merican Indian, /hite, etc. /hite			
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Baltimore, Ma	Pages 1 and 2 s nent of Health ar int: if Item 27 is iry or other trau		Charolette Ann Jo  20a. Method of Disposition  1	Ohnson/si	20b.		6 Mor	is I	Dr.,		bury,	MD 218		own, State	
Balti	permit. Pages Department of i Important: if Its any injury or or	-	David House Lice	ACCOUNTS ON		<b>-SP</b>	501 Sr	ow F	1111	Rd.,	Salisb	ury, N	onal A 1D 2180	ssociation 04	
8760,	Physician /Medical Examiner physician physician and physician are the prijar-transit.	dical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (and Due) o or	as a conse	quence of	ler the mod	Der	o O O	cardiac or i	respiratory ar	rest,	5	Approximate Interval Between gnset and Death	
Box 6	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fet at time of	tal death 3	□Ectopic pr □ Other <i>(sp</i>					23d.	Date of deliv Month	rery Day Year	
rds, P.O.	w requires that I been signed by should be deta	a land significant continuous con									use contribute to the cause of death?				
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe		/	Check only o				
Division of	Attending Phyer death.  ector: After this country the funeral directions and the funeral directions.	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,	Hospital: 1 Inpatient 2 ER/Outpatient 3 DO  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M						ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			fy)	
Divis	ē # ē ⊆	Certification:	3 Suicide 6 Could not to determined	building,	building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  2 Medical Exa  29b. Signature and title of certifier	hysician: To the be miner: On the basis and manner	s of examin	nowledge, dea nation and/or in	nvestigation	in my op	inion, dea	d place, an th occurred	at the time,	date and pla	d manner as s ce, and due t gned (Month,	to the cause(s)	
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3.	50		30. Name and address of person who WILLIAM ROBINS, M 31. Date filed (Month, Day, Year)	.D. 200 C		AVE.,		BURY	MD.	218	04	/			
78	St.	ate	DECOS				AND D								

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 3ªy 2005 ar **Physician** WILLS 9:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 ☐ F 70 577-50-1433 Yrs. Director 10-29-1935 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Examiner must be nutified at 1X Yes 2 No BRANDYWINE MD PRINCE GEORGE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20613 6703 BURCH HILL RD death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 MYes 2 □ NoARMY If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygien Important: If Item 27 is marked other It any injury or other treumatic event, Inspace. GOVERNMENT BRANCH CHIEF 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLOTTE WHITTINGTON RAYMOND WILLS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12604 Southern Md Blvd Dunkirk, Md 20754 DEREK HAWKINS/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHURCH CEMETERY 12-10-2005 DUNKIRK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADVANCED LUNG CANCER Priysician /Medical Due to (or as a consequence of): Examiner RESPIRATORY DISTRESS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit or Attending Physicien: The law requires thet the death certificate be executed RESPIRATORY ARREST Due to (or as a consequence of): P.O. Box 68760 CARDIAC ARREST by Physician/Medical IF FEMALE: sate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 Yes 2₽ No 1 ☐ Yes 2K No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 X Natural Injury 5 Pending death 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32247 December 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND NOOSHIN FARR M.D. 31. Date filed (Month, Day, Year) Registrar DEC 0 6 2005

		-	For State Registrar	State of M	laryland	d / Depa <i>Cer</i>	irtment of H	lealth an Death	d Mental		ene () ()	5	41287
			Decedent's Name (First, Middle, Las					te of Death 3. Time of Death					
1	Physicia /Medic		John Wesley				Dec		11:40 a <sup>M</sup>				
	Examin		4a. Facility Name (If not institution, give	street and number		4b. City, Town, or		Death		4c. County o			
			7710 Poor Hous				LaPlat		Day 1			rles	
	Funeral Director		5. Social Security Number 6. Social Security Number 1	Thu all	ge (In yrs. I 65	ast birthday) Yrs.	If Under 1 Year Months Days		Min. Jan	of Birth th, Day, Y	1940	9. Birthpl Coun Kent	lace (State or Foreign try) tucky
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
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	Manual Ma Manual Manual Manual Manual Ma Manual Ma Ma Manual Ma Ma Ma Ma		7710 Poor Hous	e Rd.			2064	б			U.S.A	•	
ω.	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. The Mcdical Examinat must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 ★ Married	12. Was Decedent Armed Forces 1 (2) Xes 2 (2)	?	'	Vas Decedent of H I Yes, specify Cuba	n, Mexican, P	? (Specify Yes Puerto Rican, et	or No-	Black	, White, i	
21215-0036	2 hours a stural', c	ted by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: lucation		16a Decer	l □ Yes 2 □ No	Specify:		16	Specify: 6b. Kind of Bus	Wh:	
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Š	is 1 and 2 should be of Health and Menta item 27 is marked other traumatic events.	၉	19a. Informant's Name/Relationship (7		or.	19h Mailin	a Address (Street				City or Town S	State Zin	Code
<u>B</u>	and 2 sho salth and n 27 is m		Geneva Mae Wes		ife	1	Poor H						
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Ë			1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		Ma	rvlan	stion ( <i>Name or</i> natory or other place d Vetera	~Dec ans!Če	7,2005 emeter	y Ch	nelten	ham	, Marylan
Baltimore,	permit. Page Department ( Important: if any injury or once.		21. Signature of Funeral Service Licen	$\prec \!$	0066	W 22	Name and Address illiams 270 Haw	ss of Facility Fune:	ral Ho	me,	P.A.		20640
	-	-	23a. Part1. Enter the disease, or compshock, or he ift failure. List only									eau	Approximate Interval Between
	Physician		Immediate Cause Final disease or condition	one cause on each	000	<b>^</b>	Can						Onset and Death
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8760,	cate b physic the b	dicai	•	d									
× 6	certifi nding	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date	of delive	erv
.O. Box	at the death certific by the attending patached for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Mont	th	Day Year
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Records,	has has	Completed							_   _	. Was an autopsy performs	pr de	nor to con eath?	psy findings available mpletion of cause of 2 No
Vital	iclan: Th certificate rector, pag	ø	25. Was case referred to medical					26. Place of	Death (Check		1		20110
<b>&gt;</b>	nysici nis ce direc	To B	examiner? 1 □ Yes 2 □ V6	Hospital: 1 ☐ Inpat		ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursi	ng Home	esiden	ce 6 Other	r (Specify	()
0 0	ng Pł		27. Manner of Death 1-□Natural 5 □ Pending	28a. Date of In (Month, D	jury Jay Ye <i>ar)</i>	28b. Time of Injury	Wor	k?		cribe how	injury occurre	d	
Sio	tendi leath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b					Yes 2 □ No					10
Division of	i or At after o Direct	Certification:	4 Homicide determined	286. Place of II	etc. <i>(Specif</i> )	ome, tarm, str //	eet, factory, office			or Town,		r or Hura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical C	29a. Certifier Certifying Ph	ysician: To the bes	of examinat	wledge, deatl tion and/or in	n occurred at the tin vestigation, in my o	ne, date and p pinion, death	place, and due occurred at the	to the cau	se(s) and man e and place, ar	ner as st	ated. the cause(s)
	othe othe	Med	29b. Signature and title of certifier	and manner s	ope up		29c. Licens	e number		290	I. Date signed	(Month, I	Day, Year)
)	F ≶ F Ö		1 Kouse	HY	lat	Û.	0.2	£25	-2		1212	10	
			30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print)	-	. ^		- /	1	
M	1401		Po Do	X 7	229	(	allafe	1 10	'/)	7	064	6	Į!
	Sta Registi		31. Date filed (Month, Day, Year) 7	2005 32. Regis	itrar's Signa	ture 55	Course						
1	-					-	1						

Physicia: /Medica Examine

Funera Directo

1	.ler													
	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.													
	For		State of	of Ma	aryland / Depa	artmer	t of H	lealth a	and M	lental Hy	giene			
	1 - For State Registrar	Certificate of Deat									41288	}		
1. Decedent's Name (First, Middle, Last)							2. Date of Death						3. Time of Death	,
1		Nicho	olas Kyle	d-Miller					Decemb	er 12	<b>,</b> 200:	5 22:00 P	A	
i	4a. Facility Name (I	f not institution	n, give street and nu	ımber)		4b. City, Town, or Location of Death				4c. Co	4c. County of Death			
	1099 Nottingham Road						E1kton				Ce	cil		
	5. Social Security N	lumber	6. Sex	7. Age	(In yrs. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt		9. Bir	thplace (State or Foreignuntry)	ın
	197-70-63	7-70-6147			6 Yrs.	IVIOTILITS	Days	Tiodis	14141.	JAN 17	1989		nsylvania	
	Usual Residence of Decedent													
	10a. State	10b. County	•		10c. City, Town or Location							10d. Inside City Limit	s	
3	Maryland	Cecil	L	E1kton								1 Tes 2 N	0	
2	10e. Street and Number					10f. Zip	10f. Zip Code 10g. Citizen of What Country?					ountry?		

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 ehow any njury or other traumatic event, the Medical Examiner must he posterione.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funers! Director: After this certificate has been signed by completely filled in by the funeral director. page 2 should be detact

Division of Vital Records, P.O. Box 68760,

1	5. Social Security Number		ge (In yrs. last birtho	Months		If Under 24 Hours		Birth Day, Yea	r)	9. Birti Co	hplace (State or Foreign		
r	197-70-6147	1 <b>X</b> M 2□F	16 Yrs	S.				7, 1	989	Pen	nsylvania		
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location												
-											10d. Inside City Limits		
cto	Maryland Cecil		E1kto	n							1 Yes 2 No		
Olre	10e. Street and Number			10f. Zij	Code			10g. C	itizen of	What Co	untry?		
a	6 Rene Carr S	treet		23	1921				Unite	ed S	tates		
Ine	11. Marital Status	t Ever in U.S.	13. Was Dece	dent of Hisp	anic Origi Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-		ce - Ame	rican Indian, e. etc.			
耳	1 X Never Married 2 Marri	ed 1 ☐ Yes 2 🛣	No	1 🗆 Yes		Specify:			Sanaify:				
d b	3 Widowed 4 Divorced	Year or Dates:						White					
Completed by Funeral Director	15. Decedent (Specify only highes	's Education t grade completed)	16a. D	ecedent's Usu Give kind of wo fe. DO NOT u	al Occupati ork done du	on ring most o	of working	16b.	Kind of B	usiness/	Industry		
E	Elementary/Secondary (0-12)	College (1-4or	(5+)	Student					High School				
ပိ	11 17. Father's Name (First, Middle, I	(act)		Studen	1	9 Mother	s Name (First, Mid				001		
Be	Sean Gerard M				'				or Sumar	110)			
2					(2)		ie Fay Wo						
4	19a. Informant's Name/Relationsh						or Rural Route Nu						
	Elsie Fay Woo	d/Hother	20b. Place of D			reet	, Elkton,				721 Town, State		
	1 XBurial 2 Cremation		Cherry	cramatory or a	other place)	De	ecember						
	4 Donation 5 Other (Sp		Method	ist Cen	netery	16	6, 2005				l, Maryland		
	21. Signature of Funeral Service I	Licensee		Hicks	Home	of Facility for T	Funerals.	P.A			land 21921		
1	Domine	8 Hill	العا						on, M	lary]			
	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each	ed the death. Do not line.	enter the mod	de of dying,	such as ca	ardiac or respirator	y arrest,			Approximate Interval Between		
	Immediate Cause (Final disease or condition  AFAD IN JURIES										Onset and Death		
	resulting in death)	Due to (or a	s a consequence of)										
	Sequentially list conditions.	b											
ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of)										
E	Cause (Disease or injury that initiated events resulting in death) Last	c											
ũ	resulting in death) Last	Due to (or a:	s a consequence of)										
lica		d											
Med	IF FEMALE:												
an/	23b. Was decedent pregnant in the past 12 months? 23d. Date of delive								livery Day Year				
Sici	1 Yes 2 No	4 Pregnant a 9 Unknown	at time of death	5 Other (s	pecify)			-	IVIC	# 10 T	Day real		
P.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cau													
9								Yes	2 <b>V</b> ONO	3 □ Pro	obably 4 Unknown		
								as an utopsy	24b.	Were au	topsy findings available completion of cause of		
Compl							, p	erformed?		Jeath?	2 No		
25. Was case referred to medical 26. Place of Death 10th													
100	examiner?									ner (Spec	at scene		
	27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Tim ay Year) Inju	e of	28c. Injury a Work?	t	28d. Descri	be how in	ury occur	red PA	SSENGEROF		
atic	1 Natural 5 Pending 2 Accident investig	10101	21	55 M	1 🗆 Ye		· CAILL	DHICH	STRU	KFI	XED OBJECTS		
i i	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Place of Ir	njury - At home, farm	, street, factor	y, office		28f. Locatio	n (Street a	and Numb	ber or Ru	ıral Route Number.		
Certification:	4 1 10111030	ounding, e		ADWA	Y		RUAD		. / "	m0	NOTTINGHAM		
	29a. Certifier 1□ Certifyin	g Physician: To the bes	t of my knowledge, o	leath occurred	at the time	date and	place, and due to	he cause	s) and ma	anner as	stated.		
Medical	(Check only 2XMedical in one)	Examiner: On the basis and manner s	of examination and/o	or investigation	i, in my opir	ion, death	occurred at the tir	ne, date a	nd place,	and due	to the cause(s)		
≥	29b Signature and title of certifier			29	c License r	number		29d F	ate signe	d (Mont)	Day Year)		

6

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 9 2005

Red cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

December 13, 2005

Wilhelm Perry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#1,2a,27,pen/I,682,2//06 II

State of Maryland / Department of Health and Mental Hygiene 05 - 8212AKG For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Perry Sean Wilhelm 5:50 P December 5, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth Month, Day, Year) JAN 3, 1961 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1∭ M 2□ F Months Hours Director 161-58-9983 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ehow ral', or items 23a or 28a-f shov Examinar must be notified at 1 X Yes 2 No Director Maryland Anne Arundel Odenton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if tiem 27 ie marked other them are only injury or other traumeric. 472 North Patuxent Road 21113 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1086-14. Race - American Indian 1 XYes 2 No 1986— If Yes, Give Year or Dates: 1992 Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify. þ 3 ☐ Widowed 4 ☒ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Plumber Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James I. Wilhelm Patricia Lamb ပို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James I. Wilhelm/Father 122 Balmoral Way, Newark, Delaware 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Crematory 13, 2005 Wilmington, Delaware Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee Risman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No autopsy performed? certificate 1X Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XXes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 06 O.C.M.E. December 6, 2005 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) AKMO111 Penn Street, Baltimore, Maryland

State Registrar STONICA

9 2005 0

32. Pigistrar's Signature

CA

31. Date filed (Month, Day, Year)

ATR

State Registrar 111 PENN STREET, BALTIMORE, MARYLAND, 21201

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

CA-TOIL

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32. Registrar's Signature

Atricia

31. Date filed (Month, Day, Year)
DEC 1 5 2005

		•	1 _ State	State of Maryland	Department of Health and Certificate of Death	6	2 U U O 4 I Z Y I
			Registrar  1. Decedent's Name (First, Middle, Last)	!		2. Date of Death	3. Time of Death
	Physici /Medio		REE	INA DI	ROWN	DEC.	Day 2005 3, 45 M
	Examir Funeral Director	er	4a. Fecility Name (If not institution, give structure)  5. Social Security Number  6. Sex  1 Number  Usual Residence of Decedent	7. Age (In ys. last	4b. City, Town, or Location of De PALDD A LLS birthday) If Under 1 Year If Under 24 F Months Days Hours M	TOWN	4c. County of Death  BALTIMERE (5)  9. Birthplace (State or Foreign Country)  Country)  9. Birthplace (State or Foreign Country)  9. Birthplace (5)
	aryland show		10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits
	with the Maryland a or 28a-1 show Le nutified at	ctor	MD BALTII	YORE BAL	TIMORE		1 ☐ Yes 2 ☐ No
	with th	Funeral Director	10e. Street and Number	EAT NIPE	10f. Zip Code	10g.	Citizen of What Country?
	ter death w Items 23a	nera	11. Marital Status 12	Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian,
21215-0036	ours after rel', or Ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Pu	erio Hican, etc.)	Black, White, etc.  Specify: WHITE
15-0	n 72 hours "naturel", edical Exe	Completed	15. Decedent's Educa (Specify only highest grade of	ion 10 ompleted)	Ga. Decedent's Usual Occupation (Give kind of work done during most of the life. DO NOT use retired)	working 16t	c. Kind of Business/Industry
212	2 should be filed within and Mental Hygiene. is marked other than " aumatic event, Ita Mar	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	DISABLED		DISABLED
	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's N	Name (First, Middle, Mai	den Sumame)
Maryland	d Ment narke	10	UNKUE	المنافع المنافع الم	Ob Marilland Advantage (Communication)	UNKNOW	) <u>/                                   </u>
Ma	s 1 and 2 should be filed within 72 hc If Health and Mental Hygiene Item 27 is marked other than "natur other traumatic event, It a Medical		19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street and Number or	1112 5	500 MD 21204
ore,	es 1 and 2 of Health of Item 27 i		20a. Melhod of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	20b. Place	of Disposition (Name of tery, crematory or other place)	Date 200	c. Location - City or Town, State
Baltimore,	Pag tment tent: I		' 4 ☐ Donation 5 ☐ Other (Specify)	MT,	CARMEL CEM.	105 /	BALTO MD.
Bal	permit. Pages Department of Importent: If II any Injury or once.		21. Signature of Funeral Service Licensee	Sparlage.	22. Name and Address of Facility SKAKDA 7-14.	2829 HUL BALTO,	MD-21224
			shock, or heart failure. List only one	cause on each line.	o not enter the mode of dying, such as card		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	A 1 7-he.  Due to (or as a consequence)	imer's Diseas	e	
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8760	icate be e physician s the buria	dicai	d.				
9	eath certifica attending pt I for use as t	/Med	IF FEMALE:	. If yes, outcome of pregnancy			
Вох	death death	ician	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal dead			23d. Date of delivery  Month Day Year
P.O.	that the deed by the detached	by Physician/Me	9 □ Unknown	9□ Unknown			
Vital Records, I	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit		Part II. Other significant conditions contri	buting to death but not resultin	g in the underlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Onknown
SCOL		Completed				24a. Was an	24b. Were autopsy findings available
I Re	The ate h	Com				- autopsy performed 1 ☐ Yes 2 ☑	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	pital:		Death (Check only one)	
of	Phys ar this eral dii	n: To	27. Manner of Death	28a. Date of Injury 28t	. Time of 28c. Injury at	g Home 5 Residence	
ion	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work?  M 1 Tyes 2 No		
Division of	after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, fate)
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier 1 Certifying Physic 2 Medical Examine one)	ien: To the best of my knowled: On the basis of examination and manner stated.	ige, death occurred at the time, date and pla and/or investigation, in my opinion, death or	ace, and due to the cause courred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
1000	vithin To the	Me	29b. Signature and title of certifier	0 4	29c. License number		Date signed (Month, Day, Year)
•			rhaven L.	1		o Da	kember 15, 2005
	8		30. Name and address of person who com	oleted cause of death (Item 23	a) (Type, Print)	200, Reic	terstown MD 21136
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature		/	
,	Regist	rar *	DFC 2 2 2005	Ben II	Sporte)		
DH	IMH 17 Rev 1/2	001			RIGINAL		

		1	For State Registrar	State of Mary	•	artment of H			giene 10 0 5	41292	
1	Physicia	an	1. Decedent's Name (First, Middle	ROYD				2. Date of Dea Month	Day Ye	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution	give street and number)  URS HOSP	TAL	4b. City, Town, or BAZ	FIMOI	ath RE	Bac 1 To	Oeath City	
نة. الأن مي	Funeral Director		5. Social Security Number 249-49-9114	6. Sex 7. Age (In 1 ☑ M 2 ☐ F	yrs. last birthday, 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, rear)	Birthplace (State or Foreign Country) unk	_
	Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10	c. City, Town or L					10d. Inside City Limits 1√√ Yes 2 □ No	_
	or 28a	Director	10e. Street and Number			10f. Zip Code	0.0		10g. Citizen of Wha		
	eath w	erail	1000 N. Gilmon	re Street nk   12. Was Decedent Eve	r in U.S. 13.	212.		Specify Yes or No-	USA 14. Race -	American Indian,	_
036	urs after de ai', or item	by Funeral	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Forces?	unk	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Pue Specify:	erto Rican, etc.)		White, etc. black	
21215-0036	be filed within 72 hours after death with the Maryland tall tygiene.  id other than "natural", or iteme 23a or 28a-f ehow event, I're Madical Era plast must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0·12)	College (1-4or 5+)	(Give	edent's Usual Occupa e kind of work done of DO NOT use retired	turing most of w	unk Porking	16b. Kind of Busin	ness/Industry unk	
and 5		Be	unk 17. Father's Name (First, Middle,	unk Last)		unk	18. Mother's N	ame (First, Middle,	Maiden Surname)	unk	
Maryland	and 2 should salth and Mer n 27 ie marke ier traumatic	ပ	19a. Informant's Name/Relations Bon Secours H		19b. Mail	ing Address (Street a	and Number or a	Rural Route Numbe reet Balt	or, City or Town, Sta imore, MI	ate, <i>Zip C</i> ode) ) 21223	
Baltimore,	Pages 1 and the total tributed to the total tributed to the tributed tributed to the tributed tributed to the tributed tributed to the tributed tri		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🂢 Other (S	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of amatory or other plac	(e)	Date	20c. Location - Cit	ly or Town, State	
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.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tim	Fetal death 3	☐Ectopic pregnancy	,		23d. Date of Month		
<b>a</b>	uires that the estinated by the ld be detached	by	Part II. Other significant conditi	ons contributing to death but r	not resulting in the	underlying cause giv	en in Part I.			ute to the cause of death?	pir
Records,	The law requires rate has been sign page 2 should be	Completed						24a. Was autop perfo	osy price dea	ere autopsy findings available or to completion of cause of ath?	
Vital	(9) 14	BeC	25. Was case referred to medica examiner?			1 04		Death Check only o	one		_
o	ing Phys	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendii 2 Accident invest	Hospital: 1 npatient 28a. Date of Injury (Month, Day Y) igation	2 ER/Outpati 28b. Time Injury	of 28c. Injur	4 🗀 Nursin	g Home 5 Resi	dence 6 Other		_
Division	al or Attending safter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could determ	not be 290 Place of Injury	- At home, farm, s (Specify)	street, factory, office		28f. Location ( City or To		or Rural Route Number,	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1. Certifyi (Check only one)	ng Physician: To the best of r I Examiner: On the basis of ex and manner state	camination and/or	ath occurred at the training a	me, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and mann date and place, an	ner as stated. Id due to the cause(s)	
	To the within 2 To the comple	¥	29b. Signature and title of certific		7	29c. Licens			29d. Date signed (	·	_
			30. Name and address of person	who completed cause of day	th (Item 23a) (Type	DO (	03035	J 11	Decemb	er 12,2005	
-21		ata	ROSITA R.  31. Date filed (Month, Day, Year	) 32. Registrar's		XX SE	cour	<> TTO.	SYLLAL		
N. Aller	Regis	ate trar	DEC 2 2		S. A.S.						

DHMH 17 Rev 1/2001

		State of Maryland	/ Depa	artment of H	ealth and N	Mental Hvo	iene	
		1 - For Registrar		tificate of L			eg. No: 005	41293
Physici		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Yea	3. Time of Death
Physici /Medic		Cherie L. Benjamin				Decembe	r 12, 200	5 2:05 AM M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of D	
		Baltimore Washington Medical Cent 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	Glen Bu	If Under 24 Hrs.	8. Date of Birth	Anne Ar	
Funeral Director		213-64-1314 1 M 2 MF 51	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct 28,	1954 Ma	firthplace (State or Foreign Country) ryl.and
pu 🖫		Usual Residence of Decedent           10a. State         10b. County         10c. City, To.	own or Lo	ostion				10d Incide City Limite
faryla shov	ō							10d. Inside City Limits 1 Tes 2 No
the N	rect	MD Anne Arundel G	1.611	Burnie 10f. Zip Code		1	0g. Citizen of What	
3a or	Funeral Director	123 Faywood Court #B		210	60		USA	,
deati	ner	11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (Spanic Origin?)	pecify Yes or No-	14. Race - A Black, W	merican Indian,
s after	by Fu	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 21 No	Specify:	, , , , , , ,	Specify:	black
hours af		3 Widowed 4 Divorced Year or Dates:	6a Deced	ient's Usual Occupa	tion		16b. Kind of Busine	
thin 72	piet	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	uring most of wor	king	, 50. Fama 5. 545110	January,
d with glene	Completed	unk unk		barmaid			tave	erns
yland ould be file Mental Hy arked oth attic avant	Be	17. Father's Name (First, Middle, Last)					Maiden Sumame) 1	
figity id fig. 2 1.2 1.3-0.030 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show raumatic event, the Marical Expedient count be notified at	မ	Ronald McKeldin	105 11-11-			ty School		7.0.71
Mal d2st thanc traum traum		1 1 21 1 1					r, City or Town, State , MD 21219	
Heal Heal tem 2		20a. Method of Disposition 20b. Place		sition (Name of	s)	Date	20c. Location - City	or Town, State
Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state	вівгу, стві	natory or other place	1			
DESILITIONE, INICITY IGNICALISTOUSSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Muchal Examiner count be notified at ance.		21. Signatur of Funeral Service Licensee Ranal S. Wade / hirector	22	Name and Addres	s of Facility Boar	d 655 W.	Baltimor	e Street
0 88588		o man fe fall		altimore,				
		23a. Part Enter the disease, or complications that caused the death. I shock or heart failure. List only one cause on each line.					est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	0000	drue In	teretion	لسم د	·	Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Immediate Cause (Final disease)  a. A( J ( ) ( )  Due to (or as a consequence)	ice of):	,				
	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ice of):	ciery	17176rt	€		
cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ate be executed at the burial-transit		resulting in death) Last Due to (or as a consequent	ice of):					
. BOX 08/00, death certificate be executed e attending physician and of for use as the burial-transit	dical	d						
COLDS, P.O. BOX 06 wrequires that the death certifica been signed by the attending ph should be detached for use as it	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	,				23d. Date of	dolivany
box leath cer attendir afor use	clan	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  25	ath 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
by the achec	hysi	9 Unknown						
ords, F.C. requires that the een signed by th hould be detache	by P	Part II. Dther significant conditions contributing to death but not resulting	ng in the u	nderlying cause give	n in Part I.			to the cause of death?
w requires w requires been sign should be						1 <b>2</b> Y	es 2□No 3□	Probably 4 □Unknown
law r	Completed					24a. Was a autops	sy prior	autopsy findings available o completion of cause of
i. The cate ha						perform 1 ☐ Yes	med? death 2☑No 1☐Y	
OT VICAL MEC Physician: The law this certificate has tral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 DEF		Othe		th (Check only on		
O	<b>—</b>	27. Manner of Death 28a. Date of Injury 28	Outpatier  b. Time of	1 28c. Injury	at Nursing H		ence 6 Other (S	oecify)
VISION Attending ar death. ector: Afte by the fune	atio	1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		res 2 No			
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home building, etc. (Specify)	a, farm, str	eet, factory, office		28f. Location (Si City or Town		Rural Route Number,
pitel or Attenous after deat breetor: filled in by the	Cer							
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel completely fi	edical	29a. Certifier  (Check only one)  2□ Medical Examiner: On the basis of examination and manner stated.	dge, death and/or in	n occurred at the time vestigation, in my op-	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) and manner late and place, and c	as stated. ue to the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and tyle of certifier		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
- > - O		I ham mo	)	03.	3475		12-12	- 2005
		30. Name and address per on who completed cause of death (Item 23	Ba) (Type,					
		30. Name and address per on who co in feled cause of death (Item 23)  DAUID ZIMZIA ZZ S. 9 (12.14)  31. Date filed (Month, Day, Year) 32. Registrar's Signature  DEC 2 2 2005	1 2+	Baltin	on m	21201		
Sta Regist		31. Date filed (Month, Day, Year)  32, Registrar's Signature	9	340				
, legist	- 2	SEUD & LUUJ BORDER DE	100					

DHMH 17 Rev 1/2001

			1 - State of Many		irtment of Health tificate of Deat		tal Hygiene Reg. No	000	41294				
		Ŧ	Decedent's Name (First, Middle, Last)				Date of Death Month Da	y Year	3. Time of Death				
Ŋ	Physici /Medic		Mary Cannon				Dec 19	7 200	5 1923 M				
	Examin		4a. Facility Name (If not in titution, give street and number)		4b. City, Town, or Location	on of Death	40	County of Deat	h				
		200	5. Social Security Number 6. Sex 7. Age (1	doca / Cente	If Under 1 Year If Und	der 24 Hrs. 8 [	Date of Birth	0 8:4	halass (Ctata as Familia				
20-	Funeral Director	81	190-44-6911	63 Yrs.	Months Days Hours		Month, Day, Year	Co	hplace (State or Foreign untry) nnsylvania				
	1		Usual Residence of Decedent				. 25, 15	72   ICI	IIISy I Valita				
	how	_		Oc. City, Town or Lo					10d. Inside City Limits				
	Ba-f e	cto	Maryland N/A	Baltin	nore				1 XYes 2 No				
	vith th	Dire	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Co	untry?				
	s 23s	Funeral Director	110 South Calhoun Street	vrin 11 S 12 1	21223 Vas Decedent of Hispanic	Origin? /Specify	Vac or No	USA 14. Race - Ame	ocan Indian				
	Item Item	'n.	11. Marital Status  12. Was Decedent Eve Armed Forces?  1 Never Married 2 Married  1. Yes 2 XNo		Yes, specify Cuban, Mexic	can, Puerto Rica	n, etc.)	Black, White					
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow ha Madigal Examiner must be notified at	by	3 ☐ Widowed 4 ☒ Divorced	1	I□Yes 2XNo Speci	eity:		Specify: Whi	ite				
2-0	natur	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupation kind of work done during m	anst of warking	16b. K	(ind of Business/	Industry				
21	thin Med	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life. C	OO NOT use retired)	Tool or troiling							
	led w lygier her th		12		Homemaker	atherta Nama (Fi	rst, Middle, Maider	Own Home	9				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Exeminer must be notified at	Be	17. Father's Name (First, Middle, Last)  Joseph Walsh		18. MO								
7	2 should and Me Is mark sumatic	P <sub>C</sub>	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Nun		n O'Boyl		Zip Code)				
<b>S</b>	and 2 sealth ar n 27 is	'n	Heather Postlethwait, daught	er 1605	Lefrak Court	Herndo	n Virci	nia 2017	0				
ē,	s 1 and 2 if Health Item 27 other tra	1 8	20a. Method of Disposition	20b. Place of Dispo-	sition (Name of natory or other place)	Date	20c. L	ocation - City or	Town, State				
E	Pages nent of the ant: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	-	ematory Inc.	12/20/	05 Ba	ltimore.	Maryland				
Baltimore,	permit. Page Department o Important: If any Injury or once.		21. Signature in Ineral Sex celuic insee	Name and Address of Fa	clity Lety Of	Marylan	d Inc	The state of the s					
Inomas Gregoty 299 Frederick Ro							altimore	, Maryla	nd 21228				
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not enti	er the mode of dying, such	as cardiac or res	spiratory arrest,		Approximate Intervat Between Onset and Death				
	Physician		mmediate Cause (Final disease or condition esulting in death)  a. Castro mitestand beautiful blee diagray  Due to (or as a consequence of):										
	/Medical Examiner	į.											
		ē	if any, leading to immediate  b. Due to (or as a co	consequence of):	(greation								
<b>Y</b>	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Mation								
o,	be executed icien and burial-transit	Exa	resulting in death) Last Due to (or as a c										
8760,	The law requires that the death certificate be executed tile hes been signed by the ettending physicien and oage 2 should be detached for use as the burial-transit	dicai	d.										
9	e as t		IF FEMALE:										
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 mophs?	Fetal death 3	Ectopic pregnancy			23d. Date of del Month	very Day Year				
	that the death certific ed by the ettending of detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time 9 ☐ Unknown	ie or death 5 L	Other (specify)								
P.0	signed by	y Ph	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause given in Pa	art I.	23e. Did tobacco	use contribute to	the cause of death?				
Records,	quires n sign ald be	Completed by					1 🗆 Yes 2	. □No 3□Pr	obably 4 Dinknown				
00	s been si	ojete					24a. Was an	24b. Were au	topsy findings available				
Re	ysician: The lavis certificete hes director, page 2	mo					autopsy performed? 1 ☐ Yes 2 ☐ No	death?	completion of cause of 2 □ No				
Vital		Be C	25. Was case referred to medical examiner?		26. Pk	ace of Death (CI							
of V	Physician: this certific al director,	To I	1 ☐ Yes 2 ☐ No	2 ER/Outpatien			5 Residence		cify)				
n c	ing P After t unera	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Work?		Describe how inju	iry occurred					
Sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	- At home, farm, str	M 1 Yes 2		Location (Street a	nd Number or Bu	iral Route Number.				
Division	after after Direct	Certification:	4 Homicide determined building, etc. (	(Specify)	eer, ractory, onice	201.	City or Town, Stat		rar riodio rambor,				
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral of		29a. Certifier 1 Certifying Physician: To the best of r	my knowledge, death	n occurred at the time, date	and place, and	due to the cause(s	s) and manner as	stated.				
	n 24 the Fu	Medicai	(Check only one)  2 Medical Examiner: On the basis of examiner and manner states		vestigation, in my opinion, o	death occurred a	t the time, date an	d place, and due	to the cause(s)				
	To the within 2 To the complet	Ž	29b. Signature and title of certifier		29c. License number	er		ate signed (Monti	-				
)	(		than I hap	MO	116666		D	ec. 19,	2005				
	Vo		30. Name and address of person tho completed ause of deal	th (Item 23a) (Type,	Print) Spet Sa	11	0	, ,					
		240	31. Date filed (Month, Day, Year) 32. Redistrar's	Signature #	Street Da	14 mon	e, M	21201					
	Sta Regist		DEC 2 2 2000	Aller Siller St	100080								

			1 = For State Registrar	State of Ma	ryland	/ Departm				iene 05	41295
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Karen Jo Chapman						2. Date of Deat Month	Day	Year 005 5:45 Q M
	Examile Funeral Director		Z13-30-468/	Hospital	(In yrs. las	nter R	OSe.C	or Location of Death C. C. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 13	Granty (Year)	of Death  (MOCC  9. Birthplace (State or Foreign Country)  Maryland
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County			Town or Location					10d. Inside City Limits
	ith the Marylandor 286-1 show	Director	Maryland Baltimore  10e. Street and Number	2	Nott	ingham 101	. Zip Code		11	Og. Citizen of W	1 □ Yes 2 No /hat Country?
aren	s after death w	by Funeral L	9502 Perry Hall Bo	Dulevard  2. Was Decedent E Amed Forces?  1		. 13. Was D	21236 ecedent of F specify Cub es 25 No	Hispanic Origin? (Sp an, Mexican, Puenc Specify:			- American Indian, K, White, etc.
$\geq$	21213-UU36 I within 72 hours af jene. I then "neturel; or the Medical Exem	leted t	15. Decedent's Educ (Specify only highest grade	ation		16a. Decedent's	Usual Occup	pation during most of work	ing	16b. Kind of Bu	
9	offled within I Hygiene.	e Completed	Elementary/Secondary (0·12) 12  17. Father's Name (First, Middle, Last)	College (1-4or 5+	-)	Data Pr		-			arm Insurance
Pr	E da B	To Be	John Norman Chapma					Virginia	a Lee Peo	dicord	
_	Heal Heal		19a. Informant's Name/Relationship (Type Kathy J. Yearley 20a. Method of Disposition	oe, Print)	20b. Pla		xtail	Road, Har	npstead i	Marylan	
	ITIMO It. Page It. Page Ithment of Irlant: If Injury or		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		1	ns Chape	1	12,			Hill, Maryland
Ġ	Dermi Permi		I from 9 for	m		Peace 2325	ful Al York F	lternative Road Timor	es Funera nium Mary	al&Crema yland 2	ation Ctr.P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line  Colon  Due to (or as a	· C	ancer	mode of dylr	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
\ \ \ 	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, I sty, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a							
	F.O. BOX 68/60 nat the death certificate be e d by the attending physiciar letached for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 極 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal d	leath 3 □Ectop	ic pregnancy r (specify) _	у		23d. Date Mon	e of delivery tth Day Year
	uires that it signed by lid be deta	by	Part II. Other significant conditions con	tributing to death bu	t not result	ing in the underlyi	ng cause giv	ven in Part I.			bute to the cause of death?  3 Probably 4 WUnknown
c	LIVISION OT VITAL HECOPIAS, I or Attending Physicien: The law requires taller death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was ar autops perform	ned? d	Vere autopsy findings available rior to completion of cause of eath?
	NY VICAL ME hysicien: The la his certificate ha I director, page 2	BeC	25. Was case referred to medical examiner?					26. Place of Deat	1 ☐ Yes 2 h (Check only one	-	☐ Yes 2 🗷 No
,	or V hysic his ca al dire	2	1 ☐ Yes 2 No	ospital: 1 X Inpatien			DOA		me 5 Reside	nce 6 □Othe	r (Specify)
	SION C tending P leath. tor: After t the funera	Certification:	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		l8b. Time of Injury M		ry at rk?  Yes 2 □ No	28d. Describe ho		
	DIVI	Certif	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)				City or Town	, State)	er or Rural Route Number,
	he Hosp in 24 hou he Fune pletely fi	ledical	one)	ician: To the best of ter: On the basis of and manner stat	examinatio	ledge, death occu on and/or investiga	rred at the til ation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and mar ite and place, a	nner as stated. nd due to the cause(s)
	To 1 with To 1	Σ	29b. Signature and title of certifie	w 7			29c. Licens	o 0 55	79/	od. Date signed	(Month, Dey, Year)
	١		30. Name and address of person who could be the same and address of person who could be  15 9000	Fra	nKlin S	quare	Drive	Balti	more, r	1821237	
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	to have	M 9			•	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 23e per doc 9850 12-22-05 vt. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year MANA 50 KO-USISTADIRIB. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GOODSAMARITAN WRSING LETTER BALTIMORE | Months | Days | Hours | Min. | Months | Days | Hours | Min. | Months | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 F 30 Yrs. Director SH3 34 3843 FIARYL Usual Residence of Decedent with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALT: MORE ( presser ) 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ items 23e AVEN BLVD. # 52 -S.A. P701 91330 Tac Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 ☐ Divorced STIHW "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) t and 2 should be filed within dealth and Mental Hygiene. m 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER Home 87RS-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPHINE JOSEP12 KOSOJIT 2 180DE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) & \\arrack{\partial}{\partial} 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other treu once. TERRY HALL SOKOLIZ CAMOHT BROOK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HOLY GOSLORP BAY1: Was 2002 PRYLAR 22. Name and Address of Facility = NEM EVANUE HARVEL OF NORO Number of Fund rail Service Lice see 31237 121 Danz COLA 1ARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 23 10ha disease or condition resulting in death) /Medical Due to (or as a consequence of): W 4 Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? for Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. P detached Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₩ No Jas page cate h 2 No Division of Vital 1 Yes 2 No Hospitel or Attending Physicien: certific Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner Hospital: 1 🔲 Inpatient Other: 4Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After 1 SNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one)

2

State

Registrar

To the

31. Date filed (Month, Day, Year)

DEC 2 2 2005

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

29c. License number

30

Baltimore. Hd - 21239.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem#1,2,perMD?G850,12-30-05 TI State of Maryland / Department of Health and Mental Hygiene O C 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 19 **Physician** <del>20</del>, 2005 10:10 AM Mary Lucile Close Dec. Lucile Robinson Close /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Baltimore Oak Crest Village
5. Social Sécurity Number 6. Sex If Under 1 Year Tf Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 10, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2-F 88 Yrs 1917 Maryland Director 220-18-9562 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Exanduar must be ricillised at Maryland Baltimore 1 ☐ Yes 2 X No Baltimore Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8810 Walther Blvd., Apt. 1004 21234 USA or items 23a Funeral should be filed within 72 hours after death nd Mental Hygiene. marked other then "neturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5-0036 1 ☐ Yes 2 ☐No Specify: Specify: White þ 3 ☐Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) to and 2 should be fill Health and Mental Hem 27 is marked off John Andrew Robinson Mary Lucile Robinson Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 le ury or other trae 5 N. Earlton Ext. Havro de Grace, ND 21078
a of Disposition (Name of Date 20c. Location - City or Town, State James Close/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) -20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Hilltop Service Corp. 12-21-05 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications plat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, should be 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funerel Director: After the completely filled in by the funeral 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - m 058646 DOCOMBOT 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville MD 21234 Booleward Monias 5800 walthor Anna 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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State

Registrar

DEC 2 2 2005

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State of Maryland / Department of Health and Mental Hygienes or

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow

Baltimore, Maryland 21215-0036

Physic /Medi Exami

To the Hospital or Atlanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and

Division of Vital Records, P.O. Box 68760,

	For State Registrar	Otato of Mary	Cert	ificate of			Reg. No.	) 4	1290		
	1. Decedent's Name (First, Middle, La	st)				2. Date of De. Month		V	3. Time of Death		
ician dical	CTATELICE LITUELL	ffe Carlos, J	r.			Decemb	er 15, 2	005	3:12 P M		
iner	4a. Facility Name (If not institution, giv			-	Location of Death	1	4c. County of				
	Upper Chesapeake	Medical Cent	er	Bel Ai			Harfor	d			
al	Social Security Number     6. S	DAM OFF	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Yəar)	9. Birthpla	ace (State or Foreign		
r	//0-30-2525	4	3 Yrs.			May 26	, 1962	_Ant	igua		
	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Loc	ation				10	d. Inside City Limits		
5									1 ☐ Yes 2 🛣 No		
Director	Maryland Harford	<u>d</u>	Forest H	T			10g. Citizen of W	hat Count	n/2		
		alla Course		10f. Zip Code					Ty !		
Funeral	1634 Apt B Miche		- 11 C 12 W	21050		nosity Voc as No	Antigu	- America	no Indiao		
1	1 1. Marital Status 1 ☐ Never Married 2 🕅 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No	110.5. 15. VV	Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)	Black	, White, e			
h v		If Yes, Give Year or Dates:	11	☐Yes 2XNo	Specify:	Bla	ck				
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Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Gener	al Manaq	er		Restaur	ant (	Chain		
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-	19a. Informant's Name/Relationship (				and Number or Ru						
	Veronica Anthony	y Carlos - Wi	fe 1634 .	Apt B Mi	chelle C	ourt, Fo	rest Hil	1, M	D 21050		
	20a. Method of Disposition		b. Place of Dispos	ition (Name of	201	Date	20c. Location - 0	City or Tov	vn, State		
	1 Description 3 Name Removal from State   Cemetery, crematory or other place)										
	4 Donation 5 Other (Specify) St. John's Cemetery 12-23-05 St. John's 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Ho										
	Stall (100	Conde	1	317 Coke	sbury Ro				•		
, ec	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to final political states are cause. Enter Underlying Cause (Disease or injury)										
Modical Examinar	resulting in death) Last	cDue to (or as a con	sequence of):								
Dhyeician/Ma		23d. Date Mon	of deliver	y Day Year							
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٥		3,	Str	eet		US P	2620	JELOW A	Ly MD		
icolpo	29a. Certifier 1 ☐ Certifying Pi (Check only one) 2 ☑ Medical Exa	hysician: To the best of my miner: On the basis of exan and manner stated.									
1	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, D	Day, Year)		
	Jet Co.	· - Kal	00	0.C.	M.E.		December	16,	2005		

State Registrar 30. Name and address of person who completed cause of de

31. Date filed (Month, Day, Year)
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(Type, Print)
111 Penn Street, Baltimore, Maryland

		-	For State Registrar	State of Ma	aryland /		artment of I tificate of		d Mental Hy	giene Reg. No.	5 412	299
	Physicia	an	1. Decedent's Name (First, Middle, Last,	DUBERST	TEIN	,			2. Date of De Month	Day	Year	e of Death ・ 2こり M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,		<i>DEC</i> eath	4c. Count	ty of Death	- 2C P
			VANTASE HOUSE  5. Social Security Number 6. Se		e (In yrs. last	hirth day)	Co LUM		Hrs. 8, Date of Birt		SWARD	ato or Foreign
	Funeral Director				98	Yrs.	Months Days		Min. (Month, Da 04/30	y, Year)	9. Birthplace (Sta Country) New Yo	rk
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Insid	e City Limits
	a-f sho	ctor	MD Howard		Colu	mbia					1 🗆 1	Yes 2 No
	with the	Director	10e. Street and Number	+ Pood			10f. Zip Code Columi	nia		10g. Citizen of USA	What Country?	
	death	Funeral	5400 Vantage Poin  11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V		Hispanic Origin	? (Specify Yes or No	14. Ra	ce - American Indiar	٦,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Department of Health and Mental Hygene. Importent: If Item 27 is marked other than "natural; or Items 28a or 28a-f show any fujury or other traumatic event, Ita M. Jical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married  ③☐  Widowed 4 ☐ Divorced	1 Yes XXN If Yes, Give Year or Dates:	10		Tes, specify Cub		deno rican, etc.)		ack, White, etc. ify: White	
8	72 hour	ted	15. Decedent's Edu (Specify only highest grad	ucation	10	6a. Deced	lent's Usual Occu	pation	working	16b. Kind of 8	Business/Industry	
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	nd 2 st lith and 27 is n r traun		19a. Informant's Name/Relationship (7) Ellen Sobo	rpe, Printi)					r Rural Route Numbe , Unit 51(			L 33324
altimore,	ges 1 a of Hea if item or otha		20a. Method of Disposition  ▼ □ Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place	of Dispo	sition (Name of natory or other pla	ісе)	Date	20c. Location	- City or Town, State	
Ħ H	iit. Pagartment ortent: injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	)	Jude		[emoria]		/23/2005			Tno
Ba	Department of the sany is		Max. Has	ma	_		55 Twin		Witzke F Rd. Col		MD 21045	Inc.
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7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events	o construction	а попинучный	De	THE NO	TIA				
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687	ificate t g physic as the b	edical		d								
Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal de	ath 3	Ectopic pregnanc	·y			ate of delivery	Year
o.	the deay by the a ached fo	Jysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 [	Other (specify) _					
α,	res that igned b	by	Part II. Other significant conditions co	ntributing to death bu	ut not resultin	g în the ur	nderlying cause gr	ven in Part I.			ntribute to the cause	of death?
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of	Phys r this ral di	n: To	27. Manner of Death	Hospital: 1 🗀 Inpatie 28a. Date of Injur (Month, Da)	ry 281	b. Time of	28c. Inju	ry at	ng Home 5 Resident			
Division	tending feath.	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Injury	M 1	rk? ]Yes 2 □ No				
Σ	or Attendations after death Director:	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Num vn. State)	nber or Rural Route N	√umber,
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	6		30. Name and address of person who c	ompleted cause of de	leath (Item 23	la) (Type,	Print) Annie	PLAZE	SENTE 3	14 BAC	LIMORE	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perilf C852, 2/8/06 TT State of Maryland / Department of Health and Mental Hygien@ 0 5 41300 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2:00P M John Joseph DiGiorgio Dec 21 2005 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 2606 Point Lookout Cove Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8099 8. Date of Birth (Month, Day, Oct 18, Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) 1 ₹ M 2 □ F 129-24-8009 75  $\bar{1}930$ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 2606 Point Lookout Cove USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any hingry or other traumatic event, the Marical Examiner man be nutified at once.

Baltimore, Maryland 21215-0036

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the ettending physicien To the Hospital or Attending Physicien: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificete has been signed by t

Division of Vital Records, P.O. Box 68760,

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ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:1953-	65 1□Ye	s 2√€ No Spe	ecify:	Specify: W	nite						
etec	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Decedent's U	Isual Occupation work done during Tuse retired)	most of warking	16b. Kind of Busines	s/Industry						
Be Completed by Funeral	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Senior S		alyst	IBM							
9	17. Father's Name (First, Middle, Last)				fother's Name (First, Middle	, Maiden Sumame)							
0	Salvatore DiGiorgi	io		Ma	arienella Cuf	fari							
	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Addr	ess (Street and N	umber or Rural Route Numb	er, City or Town, State,	Zip Code)						
	Raya DiGiorgio	Wife	2606 Poi	nt Looko	ut Cove, Anna	polis, MD	21401						
	20a. Method of Disposition	20b. P	lace of Disposition ( emetery, crematory	Name of	Date	20c. Location - City of	r Town, State						
	1√Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				n 12-27-05	Pinelawn,	NY						
	21. Sign with f uneral Service Licens	500	22. Name Fink	and Address of F Funeral	Home, P.A.								
_			426	Crain Hw	y SW, Glen Bu	rnie, MD	21061						
	23a. Part   Enter the disease, or comp shock or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the r	node of dying, suc	h as cardiac or respiratory a	arrest,	Approximate Interval Between						
	Immediate Gause (Final disease or condition	· CANCIE	? Par	CREA (			Onset and Death						
	resulting in death)	Due to (or as a consequ			•		1 2 45 5						
		b					LIMOS						
ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uavida offic										
Ē	ause. Enter Underlying ause (Disease or rinjury nat initiated events												
×a	resulting in death) Last	C. Due to (or as a consequ	uence of):										
<u> </u>		d											
듗		u											
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□Ectopi	c pregnancy (specify)		23d. Date of do Month	elivery Day Year						
5													
a by	Part II. Other significant conditions co	intributing to death but not resi	ulting in the underlyir	ng cause given in F		tobacco use contribute  Yes 2™No 3□F	to the cause of death?  Probably 4 Unknown						
					24a. Wa	24h Word	autoney findings available						
2					auto	ppsy prior to death?	autopsy findings available completion of cause of						
3					1 ☐ Yes		s 2 No						
0	25. Was case referred to medical examiner?				Place of Death (Check only	one)							
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4[	☐ Nursing Home 5 🙀 Res	idence 6 Other (Sp	ecify)						
callon, 10	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes		how injury occurred							
	2 Accident Investigation 3 Suicide 6 Could not be		ome form street for			(Street and Number or I	Pural Pauta Mumbar						
ertil	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	ctory, office	City or To	(Street and Number or F wn, State)	nurai noule Number,						
Medical Certifi	29a. Certifier \(\(\frac{\text{Certifying Phy}}{0.000}\) \(\text{2} \sum \text{Medical Exam}\)	ysician: To the best of my kno niner: On the basis of examinal and manner stated.	wledge, death occur tion and/or investiga	red at the time, da tion, in my opinion	te and place, and due to the , death occurred at the time	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)						
ž	29b. Signature and tills of certifier	0/1,		29c. License num	ber	29d. Date signed (Mor	nth, Day, Year)						
	> Xthy 1/ Wok	Mun		D081	1/8	DEC 2	2,2005						
	30. Name and address of person who o	,	23a) (Type, Print)	07-0	h 0:		, , ,						
	31. Date filed (Month, Day, Year)	JHTKINS 9		BAIL KI	7- AMNABLIS	-MD 2	1401						
e	ST. Date filed (Month, Day, Year)	20	W Smerk	P									

State

Registrar

DEC 2 2 2005

			1 - For State Registrar	State of Marylar		rtment of			ene 2005	41301
*	Physici		1. Decedent's Name (First, Middle, Last)	Fei	rgus	on		2. Date of Death Month	Day Year	3. Time of Death
1 de	/Medic Examir		4a. Facifity Name (If not institution, give s	etreet and number)	Hosp.	4b. City, Town,	or Location of Deal	h	4c. County of Dea	
· 矣.	Funeral Director	Alt	5. Social Security Number  2 (9-62-3253 10)  Usual Residence of Decedent	7. Age (in yrs.	Yrs.	Months Days			rear)	thplace (State or Foreign buntry)
	Maryland	tor	10a. State 10b. County	/A 10c. C	ity, Town or Loc	ation 2	200 00 1			10d, fnside City Limits 12 Yes 2 ☐ No
	h with the 23s or 28s	Funerai Director	10e. Street and Number 2902 Rd G2V	wood Are		10f. Zip Code	1215	10	g. Citizen of What Co	ountry?
980	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-1 ehow frs Modical Exercities Fransi Re notified at	by		12. Was Decedent Ever in L Armed Forces? 1 XYes 2 □ No ( () If Yes, Give	72 - If	as Decedent of Yes, specify Cut	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 Ie marked other then "neturat", or Items 23s or 28s-1 show other traumatic event, the Medical Exertifier reast its notified as	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) Colfege (1-4or 5+)	(Give k	O NOT use retire	during most of wa	rking 16	Self-en	np ligell
Maryland	should be fited nd Mental Hygi marked other umatic event, II	To Be (		erguson			Virgi	me (First, Middle, Ma	'ousin	
	1 and 2 sh Health and tem 27 le m		19a. Informant's Name/Relationship (Type Michelle Ferry Liston 20a. Method of Disposition	20b.	2902 Place of Disposi	Ridger	and Ave	ural Route Number, (		215
altimore,	Page ment c ant: If ury or		1 \Burial 2 \Cremation 3 \Red 4 \Don/ttion 5 \Other (Specify) 21. Signal, re of Funeral Service Licen le	emoval from State	Cemetery, crema	atory or other pla	t Vet. 12-	29-05		nicis, MD.
Ä	permit. Depart Import eny inj		23a. Party Enter the disease, or complice shock, or bearly grifure. List only on	Lullus cations that caused the dea	- na	2405 i	n. wall	ace trenero	Q Service	Bacto, md, 2,229 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACQUIRED  Due to (or as a consec	i MMi		EFICIEN		ROME	Interval Between Onset and Death
8760,	cate be executed  by stoian and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	quence of): HE	MORRI	DISEA HAGE	SE.		< 1 wort
	The law requires that the death certificate ile has been signed by the attending physi page 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. ff yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al déath 3 ⊟E	Ectopic pregnand Other (specify) _	у		23d. Date of deli	ivery Day Year
ds, P.	uires that i signed by Id be deta	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the und	derlying cause gr	ven in Part I.		cco use contribute to	. /
al Records,		Completed						24a. Was an autopsy performe	dy death?	topsy findings available completion of cause of
of Vital	Phyeiciar this certif ral directo	To Be	1 162 2 140		ER/Outpatient	3□ DOA Ott	nor-	ath (Check only one) Iome 5 ☐ Resident	ce 6 □Other (Spec	cify)
Division	Jing Afte fune	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of Infury	28c. Inju Wo M 1	ryat rk? ]Yes 2 □ No	28d. Describe how	injury occurred	
Ž	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide 6 Could not be determined	28e. Place of fnjury - At h building, etc. (Specia	fy)			City or Town,	ŕ	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death of ation and/or inve	occurred at the ti stigation, in my	me, date and place opinion, death occu	, and due to the causered at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
)		2	29b. Signature and title of certifier  Daught	love, MI		AT 2	438946.	-F14 D	. Date signed (Month	, 19, 2005
	341		30. Name and address of person who cor Danifela. Jel	lovac, Mi	DU	nion	Memor	ial Hos	mtal,	MD
	Sta Registr		31. Date fifed (Modth, Day, Year) U DEC 2 2 20	32. Registrar's Signa	ature	all!			,	

			State of Maryland / Department of Health and Mental Hygiene  1 - For Registrer  Certificate of Death  Reg. No. 005 4 1303
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year Year H: 25PM  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death 4c. County of Death
	Examin	er	Howard County General Hospital  Columbia  Howard
	Funeral Director		5. Social Security Number 220-36-1388 6. Sex 1 D M 2 F 67 Yrs.
re, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. itam 27 is marked other then "natural", or Items 23e or 28e-1 show other traumetic event, it is Madical Executes the nutilised at	To Be Completed by Funeral Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   1
Baltimore,	permit. Pages Department of t Important: If its any injury or o		1 Removal from State  1 Donation 5 Other (Specify)  21. Signate of Funeral Service Licensee  22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045  23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
8760, <	rate be executed / Medical Examiner and Interpretation and Interpretation into buriar-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
P.O. Box 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Minknown
Vital Records,	The ate h page	Completed	FUNGBUY RINARY TRACT INFECTION  24a. Was an autopsy performed? 1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vit	anding Physeath. or: After this he funeral di	ertification; To Be	25. Was case referred to medical examiner? 1   Yes   2   No
_	Hospita 4 hours Funara tely fille	edical Ce	29a. Certifier (Check only one)  10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	To the within 2 To tha complet	Me	29b. Signature and title of certifier W MD 29c. License number D 53 SS 7 DEC, 13 2005
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WENNETH EET NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WENNETH EET NO 20201
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 2 2005  32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Edward Foley, Jr. DEPEMBER 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Tan. 14, 1 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 70 1935 Virginia Director 230-46-8461 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Harford Edgewood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2008 Cherry Road 21040 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 🎾 No Specify: 3 Widowed 4 Divorced Year or Dates: White Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other treumatic svent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance 12 Insurance Agent marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Stawerdman Edward Foley, Sr. Carrie Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Importent: If item 27 Is any injury or other treaugnce. 2008 Cherry Road, Edgewood, Maryland 21040 Ruth P. Foley - Wife altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Paul's Luth. Cem. 12/22/05 Aberdeen, Maryland permit. 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760. Physiclan/Medical asi IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aftert Certification: To the Hospital or Attending 1 Naturai Injury 5 Pending after death.

Director: Afi 1 🗌 Yes 2 🗆 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 1/2001

State

31 Date filed (Month, Day, Year)

Store Con

own

32. Registrar's Signatu

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 18, 2005 **Physician** 1:45 PMM Elizabeth Ingeborg Goodwin /Medical 4c. County of Death Frederick 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerford Assisted Living & N.H. Frederick 8. Date of Birth Month, Pay, Year) May 10, 1916 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M XXF 047-03-9759 89 Yrs. Connecticut Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Madical Examiner must be notified at Bethesda 1 XXes 2 □ No Maryland Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6214 Verne Street 20817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or then any injury or other traumatic event, the Madical Exercutions. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rudolf W. Swensk Elizabeth Bengtson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Christopher Goodwin, son 18331 Comus Rd. Dickerson, Maryland 20842 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Smithsburg Crematory Dec. 21, 2005 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD M00255 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Zheimens **Physician** Dementic YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at the detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ischamic AHACK 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pulipidenia 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physicien: The within 24 hours after death.
To the Funerel Director: After this certificate I completely lifed in by the funeral director, page Osteo Docoio

25. Was case referred to midical examiner? 1 ☐ Yes 2 No 1 Yes Division of Vital 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier December 19, 2005 D 46248 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Clessels. Registra

			1 = For State Registrar	Alkelid	State of	Maryland / Be	partment of Certificate	if Méalth and of Death	d Mental Hy	ygiene Reg. No		41306
п	Physici	an	Decedent's Nam	ne (First, Middle, La	ast)				2. Date of D Month	Da	y Year	3. Time of Death
	/Medi		REBECCA					SBERG	DECEMB			5:48 A M
7	Examir	ner	,		ve street and numb	er)		m, or Location of De	eath		County of Death	
M	# # # # # # # # # # # # # # # # # # #		5. Social Security 1	R NURSING		Age (In yrs. last birtho	WHEA		Irs. 8. Date of 8		10NTGOME	
×	Funeral Director		218-74-	i	1□M 2∏F	96 Yr	Months Da	ays Hours Mi	12/28/	ľ908	) Co	nplace (State or Foreign untry) MD
	p.		Usual Residence	1		10. 65. 7						
	ehow	7	10a. State MD	MONTGOM	EDV	SILVER S						10d. Inside City Limits 1 ☐ Yes 2 No
	he M	ecto	10e. Street and Nu		LNI	SILVER S	10f. Zip Cod	do.		10a C	tizen of What Co	
	with	급		SUMMERWOO	D DDIVE		2090			-	U.S.A.	und y :
	Jeath ma 23	era	12309 3	DOMINERMOO	12. Was Decede		13. Was Decedent	of Hispanic Origin?	(Specify Yes or N	1	14. Race - Amer	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. Item 27 ie marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Wedical Exert and the modified at	by Funeral Director	^	ried 2 Married 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	X ио	If Yes, specify (	Cuban, Mexican, Pu No Specify:	erto Rican, etc.)		Black, White Specify: W	e, etc. HITE
5-0	72 hc	Completed	(Spe	15. Decedent's E	ducation ade completed)	- (0	ecedent's Usual O	one <i>duri</i> na most of v	vorking	16b. k	Kind of Business/l	ndustry
121	han "	m p	Elementary/Sec		College (1-4	or 5+)	e. DO NOT use re	etired)			OUN HOME	
121	iled v tygie ther t		12 Father's Name	(First, Middle, Las	t)	ווטויוב	MAKER	18 Mother's N	lame (First, Middle		OWN HOME	
Maryland	should be filed within and Mental Hygiene.  • marked other than " umatic event, the Mar	o Be	LOUIS	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	GINSE	FRG	SARA		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,	GINSBERG
Σ	2 shout and Me le mark aumati	ှင		Name/Relationship	(Type, Print)			reet and Number or		ber, City	or Town, State, Z	
Z	and 2: ealth ar n 27 le		LOIS GF	REENSPAN	/ NIECE	125	09 SUMME	RWOOD DRI	VE - SIL	VER	SPRING.	MD 20904
J.	ss 1 and 2 of Health Item 27 I		20a. Method of Dis	sposition		20h. Place of D	isposition (Name o	of I	Date		edale City or	
Baltimore	permit. Pages Department of I important: If Its any injury or o			5 ☐ Other (Spec	Removal from Sta fy)	" AGUDAS ANSHE S	Crematory or other ACHIM FARD CON(	3. 12/	/21/2005			
at	permit. Pag Department Important: I any injury o		21. Signature of F	uneral Service Lice	nsee		22. Name and A	ddress of Facility S	OL LEVIN	SON	& BROS.,	INC.
	40 E # 9		,	10				STERSTOWN			SVILLE,	MD 21208 Approximate
V	Physician /Medical Examiner	Examiner	shock, he immediat a ause disease condition resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease o that initiated event resulting in death)	onditions, mmediate erlying r injury ts	a	as a consequence of)	leron	e Carde	pilosii.	la s	Disan	Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical		l	d	as a consequence or						
P.O. Box (	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?		n 2 ☐ Fetal death t at time of death	3 ☐ Ectopic pregn 5 ☐ Other (specify				23d. Date of deli Month	very Day Year
Records, P.	quires that an signed b uld be deta	ed by Pt	Part II, Other sign	ificant conditions	contributing to deat	h but not resulting in th	e underlying cause	e given in Part I.				the cause of death?
900	law requir as been si 2 should	Completed							24a. Wa	s an	24b. Were au	lepsy findings available ompletion of cause of
Ä		E O							peri	formed?	death?	2 □ No
Vital	Physician: The laver this certificate has all director, page 2	Be (	25. Was case refe examiner?	erred to medical					Death (Check only	one)		
of \	hysii his ca	2	1 ☐ Yes 2 ☐	NO	Hospital: 1 ☐ Inp				gHome 5□Res	sidence	6 ☐Other (Spec	ify)
Division o	fter their	Certification:	27. Manne of Dea Natural 2 Accident 3 Suicide	ath 5 □ Pending investigate 6 □ Could not	00		М	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe			
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4  Homicide	determined	286. Place of building.	Injury - At home, farm, etc. (Specify)			City or To	own, State	e)	ral Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	29a. Certifier (Check only one)	2 Medical Exa	miner: On the basi and manner	est of my knowledge, of s of examination and/or stated.	eath occurred at the investigation, in a	ne time, date and pla my opinion, death oc	ace, and due to the courred at the time	a cause(s , date an	d place, and due	stated, to the cause(s)
)	To t With To t	×	29b. Signature an	d title of certifier	Len	nka	De	cense number	4	29d. Da	ate signed (Month	, Day, Year)
_	4		30. Name and add	dress of person who	NKIN	of death (Item 23a) (T	Pripary SA	OREFILE	21 R	sh	HEATON	MO
	Sta Regist		31. Date filed (Mo.	rith, Day, Year) DEC 2 2 2	100	istrar's Signature	porte					
DH	IMH 17 Rev 1/2	001				1						

		-	For State	State of Marylan	d / Department of I Certificate of		Reg. No	GUU.	4/307
			Registrar  1. Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
	Physici	_	111011	G	HILLIA	RAD	Month Da	2005	10:10 M
	/Medic Examin	_	4a. Facility Name (If not institution, give s	street and number)		or Location of Death	40	. County of Death	
34	raning.	4	JOSEPH RIC	HEY HOSF	ICE BA	-LTIMOR			1A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.)	t t Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year,	9. Birtl Co.	nplace (State or Foreign untry)
, à	Director		16-16-2159	8	4 Yrs.		EPT: 13,1	921 V	RGINIA
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
	Mary 1 eh	to	MARINANA N	1A	BA	LTIMOR	RE CI	77/	1 XYes 2 □ No
	r 28a	irec	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Co	untry?
	th with	aiD	(307 N. MO)	NASTERV A	TVE.	2122	9	45	A.
	ems erms	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, White	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No	1 ☐ Yes 22 No	Specify:		Specify:	1 11 2 11
21215-0036	72 hours atter death with the Maryland naturel', or Iteme 23a or 28a-f ehow ittel Examiner must be multified at	q pe	3 ☐ Widowed 4 🗷 Divorced	Year or Dates:	16a. Decedent's Usual Occu	nation	16b H	(ind of Business/	LACK INDICATE OF THE PROPERTY
5	in 72 n n	ojet	(Specify only highest grade	completed)	(Give kind of work done life. DO NOT use retire	during most of working	100.1		ridustry
212	d with jiene. r the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	5ECRE	=TARI	N	WIVI	YCA
	al Hyg	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	irst, Middle, Maidei	Sumame)	1
/lai	Ments Ments arked	70 E	JOHN	GUN	THER	ANNIE	=	MAS	SON
Maryland	2 sho and ie ma		19a. Informant's Name/Relationship (Ty	/	19b. Mailing Address (Stree	and Number or Rural R	oute Number, City	or Town, State, Z	
_	and lealth m 27		TONYA HILLIARD-		AGO / N. HO	NASTERY	TVE. BAL	ocation - City or	21224
Ö	ges 1 toth # Its or ot		20a. Method of Disposition 1 ØBurial 2 □ Cremation 3 □ R	*   ^	emetery, crematory or other pla	ice)	200. L	a marian	10
<b>Baltimore</b> ,	t. Pa rtmen rtent:		4 Donation 5 Other (Specify)	AR	BUTUS (EM) 22. Name and Addr		-05 101	ALTIMOI	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel; or Items 23a or 28a-f show any Injury or other traumatic event, The Machtel Examinet must be notified at an ance.		21. Signature of Funeral Service License	1/ 11 Minns	J. 5 5 E	PH H. BR	PWN JA	2. FUNE	RAL HOME
			23a. Part1. Enter the disease, or compli	cations that caused the death	h. Do not enter the mode of dy	ng, such as cardiac or re		BALTO. 1	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	· Acc +				Interval Between Onset and Peath
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	c puncreation	cancel			months
4	Examiner		Sequentially list conditions	)					
	D ≅	iner	S uential list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uance of):				
8760,	cate be executed physicien and the burial-transit	aiE		500 10 (0) 25 2 5011554	33/130 3//.				
687	icate phys s the	dicai		i				1	
Box (	attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna				23d. Date of deli	very
	death certifi e attending ed for use as	icia.	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of d		У		Month	Day Year
0	the y th iche	Physician/Me	9 Unknown	9□ Unknown					
S, D	The law requires that ste has been signed b age 2 should be deta	by P	Part II. Other significant conditions cor	ntnbuting to death but not res	ulting in the underlying cause gr	ven in Part I.			the cause of death?
brd	w requir been si should			· · · · · · · · · · · · · · · · · · ·			1 Tes 2	!□No 3□Pro	bably 4 Unknown
e C	e law r has be	Completed					24a. Was an autopsy	prior to d	topsy findings available ompletion of cause of
H	A 11	Con					performed?	death?	2 No
	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (C			- Harris
Vita	- 0 0		1 ☐ Yes 2 No	1 Inpatient 2 I	ER/Outpatient 3 DOA 28b. Time of 28c. Inju	4   Iddising Home	5 Residence  Describe how inju		Hospice
of Vital Records,	Phys r this ral di	5. To	27. Manner of Death		1mirror 142-	rk?		•	
of	ding After fune		1 Natural 5 ☐ Pending	(Month, Day Year)		Yes 2 □ No			
of	tending leath. tor: After the funer		1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)  28e. Place of Injury - At ho	M 1 Come, farm, street, factory, office	Yes 2□No	Location (Street a	nd Number or Ru	ral Route Number.
Division of Vita	or Attending ter death. irector: After by the funer		1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	M 1 Come, farm, street, factory, office	Yes 2□No	Location (Street a City or Town, Stat	nd Number or Ru e)	ral Route Number.
of	or Attending ter death. irector: After by the funer	Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Physical Certification Certificati	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specif, sician: To the best of my kno	M 1 [ come, farm, street, factory, office y)  whedge, death occurred at the i	Yes 2 No 28f.	due to the cause(s	e) s) and manner as	stated.
of	or Attending ter death. irector: After by the funer	edical Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Pending investigation 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specif, sician: To the best of my kno	M 1 [ come, farm, street, factory, office y)  owledge, death occurred at the totion and/or investigation, in my	Yes 2 No  28f.  Ime, date and place, and opinion, death occurred a	due to the cause(sat the time, date an	e) s) and manner as d place, and due	stated. to the cause(s)
of	ttending death. :tor: Alter	Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  1 Pending investigation 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification)  sician: To the best of my known of the basis of examina	M 1 [ come, farm, street, factory, office by)  by  by  cowledge, death occurred at the lition and/or investigation, in my  29c. Licen	Yes 2 No  28f.  ime, date and place, and opinion, death occurred as se number	due to the cause(s at the time, date an	e) s) and manner as d place, and due ate signed (Monti	stated. to the cause(s)
of	or Attending ter death. irector: After by the funer	edical Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and the of certifier	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification)  sician: To the best of my known of the basis of examinal and manner stated.	M 1 [ come, farm, street, factory, office by)  by  by  cowledge, death occurred at the lition and/or investigation, in my  29c. Licen	Yes 2 No  28f.  ime, date and place, and opinion, death occurred as se number	due to the cause(s at the time, date an	e) s) and manner as d place, and due ate signed (Monti	stated. to the cause(s)
of	or Attending ter death. irector: After by the funer	edical Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and the of certifier  29b. Name and address of person who come	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification) sician: To the best of my known of the basis of examination and manner stated.	M 1 [ come, farm, street, factory, office by)  by  by  cowledge, death occurred at the lition and/or investigation, in my  29c. Licen	Yes 2 No  28f.  ime, date and place, and opinion, death occurred as se number	due to the cause(s at the time, date an	e) s) and manner as d place, and due ate signed (Monti	stated. to the cause(s)
of	or Attending ter death. irector: After by the funer	Medical Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and the of certifier	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification)  sician: To the best of my known of the basis of examinal and manner stated.	M 1 Come, farm, street, factory, office by owledge, death occurred at the lation and/or investigation, in my 29c. Licen D 123a) (Type, Print)	Yes 2 No  28f.  ime, date and place, and opinion, death occurred as se number	due to the cause(s at the time, date an	e) s) and manner as d place, and due ate signed (Monti	stated. to the cause(s)

DHMH 17 Rev 1/2001

(2/18/02 10:10 P

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month WANETA VIRGINIA HOTT December 16 2005 1:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Moran Manor Nursing Home Westernport **Allegany** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1□M 201F 81 Yrs **Director** 235-32-6947 Dec. 6, 1924 Headsville, WV Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Mcdical Examinar must be notified at 10d. Inside City Limits Director 1 XYes 2 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 12 North Main Street Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o filed within 72 hours after I Hyglene. other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elderly Home Elementary/Secondary (0-12) College (1-4or 5+) Home Health Aid Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental Hitant: If item 27 Is marked oth Be Samuel Walker Hott Anna Laura Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl D. Hott/ Brother HC 63, Box 3400 Romney, WV 20a. Method of Disposition 20b. Place of Disposition (Name of Dec. 20 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Queen's Point Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Keyser, WV 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home Onan 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 27555 4 weeks /Medical Due to (or as a cons y uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🛣 No Da 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 25. Was case referred to medical examiner? 1 ☐ Yes 1 Yes 2 X No 2 No 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Hospitel or Attending Pl
 24 hours after death.
 Funeral Director: After ti Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/16/35 921244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. Frostburg Plaza Frostburg, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Hem & Speles

DHMH 17 Rev 1/2001

		1	For State Registrar	State of M	larylan	•	artment of H		nd Mental H	ygiene Reg. No	UUD	41309
	Physicia /Medic	al -	1. Decedent's Name (First, Midd Anne Hawkins	3					2. Date of Month	per 1	4, 2005	3. Time of Death 12:15 PM
	Examin Funeral	er	5. Social Security Number	Retirement (	Cente	<b>r</b> /ast birthday) Yrs.	4b. City, Town, or  Catonsv  If Under 1 Year  Months Days	ille		Birth Day, Year,	Baltimo  9. Bin Co  26 Mar	
	Director		226-32-7818  Usual Residence of Decedent  10a. State 10b. Count	**		y, Town or Lo	cation		Aug 1	3, 15	720 Mai	10d. Inside City Limits
	th the Mary or 28a-f sh e notified	Irector	10e. Street and Number	imore	.1	Catons	10f. Zip Code			10g. Ci	itizen of What Co	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23e or 28e-f show importent: if Item 27 is marked other then "natural", or Items 23e or 28e-f show property high representations of the Colliss of Space.	Completed by Funeral Director	717 Maiden Cl  11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Deceden Armed Forces 1 ☐ Yes 2 1 If Yes. Give	t Ever in U. ? ]No			228 ispanic Orig n, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	USA  14. Race - Ame Black, Whit  Specify: Wh	erican Indian, e, etc.
121	within 72 hour iene. 'then "naturat the Mevical E	ompleted	15. Decede	ent's Education est grade completed)		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	turina most	of working		Kind of Business	·
ਰ	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle Lewis Neill B	, Last)		acco	diredire	_	rs Name <i>(First, Midd</i> nor Wolfe	lle, Maidei		<u>511±P</u>
	es 1 and 2 sho of Health and I I Item 27 is my r other treums		19a. Informant's Name/Relation  John Hawkins/  20a. Method of Disposition  1□Burial 2□Cremation	spouse	1 0	717		noice	r or Rural Route Nur. Lane #508 Date	Cato		, MD 21228
Baltimore,	permit. Page Department of Importent: If any injury or once.		' 4 ☑Donation 5 ☐ Other ( 21. Signature of Puneral Servic Ronald	(Specify)	ecto				, pard 655 W	7. Ba	lt <b>i</b> more	Street
	Physician /Medical		23a. Part Enter the disease, shock or heart failure. List Immediate Conse (Final disease or condition resulting in death)	or complications that causest only one cause on each	Vb/	h. Do not ent		MD2 g, such as c	21201 cardiac or respiratory	arrest,		Approximate Interval Batween Onset and Death
,760,	te be executed XX ysician and with the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. It is that the Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d.	s a conseq	uence of):						d
O. Box 68	that the death certificate be exited by the attending physician detached for use as the buria	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fete	death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	ivery Day Year
rds, P.O.	w requires that the sbeen signed by the should be detache		Part II. Other significant condi	tions contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.				o the cause of death?
l Reco	The law ate has b page 2 sl	Completed							24a. W au pe 1 🗌 Yes	topsy rformed?	prior to death?	utopsy findings available completion of cause of
<u></u>	Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag	Certification; To Be (	25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Penc 2 Accident inves 3 Suicide 6 Coul	Hospital: 1 Inpa  28a. Date of Ir (Month, L	jury Jay Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Worl M 1 🗍	er: 4 🗌 Nur		esidence e how inju	iry occurred	cify) ural Route Number,
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	i Certifi	4  Homicide deter	mined 288. Place of i building,	etc. *(Specil	(y)	eet, factory, office	ne date and	City or	Town, Stat	e)	
	o the Hos ithin 24 ho o the Fun ompletely	Medical		el Examiner: On the basis and manner	of examina			pinion, deat		e, date an		e to the cause(s)
	⊢ 3 ⊢ ŏ		30. Name and address of perso	m who completed cause of	death (Iter	n 23a) (Type.	Print)	744	)	Du	center	14, 2003
	Sta	te.	31. Date filed (Month, Day, Yea	W 25 7	trar's Signa	aigu	Choice	La	ive Co	n top	sville	Mazland.
	Regist		DEC 2 2	2005 450	z 13°	A STATE OF THE PARTY OF THE PAR						

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary		tificate of		_	giene Reg. No.	05 41310	
	Physic	ion	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month		3. Time of Death	
	Physic /Medi		Robert Isom Jr					12	Day / 2	03 2:00 pm	
A.	Exami		4a. Facility Name (If not institution, give			•	r	r Location of Death	4c. Count	y of Death	
			Franklin Square				Baltim				
	Funeral Director		213-20-3239	57 M OF E	yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, <i>Year)</i> 1925	9. Birthplace (State or Foreign Country) Virginia	
	and and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryl f sho	Ď	MD		Baltimor	e.				1√2 Yes 2 □ No	
	1 the	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	h with	Funeral Director	1213 W. Fayette S	Street			21223			USA	
	deat deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13. V	Vas Decedent of H		Specify Yes or No	- 14. Rac	ce - American Indian,	
020	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health end Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:	nto riidan, etc.)	Specif	ck, White, etc. y: black	
21215-0020	in 72 ho n "natur Nedical	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Deced (Give life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of we	orking	16b. Kind of B	usiness/Industry	
213	filed withi Hygiene. other than	E	Elementary/Secondary (0-12) 7	College (1-4or 5+)	1abo	rer			cons	truction	
	e filed al Hygid other vent, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surnar	me)	
Maryland	should be f and Mental b s marked of umatic eve	7	Robert Samuel Iso	om Sr	,		Mi1	lie Mart	in		
lar	2 sho end i is me		19a. Informant's Name/Relationship (7)	, , ,				Rural Route Numbe	-	, State, Zip Code)	
	1 and Health em 27		Doris Blount/dau	-	1701  Ob. Place of Dispos		Street :	Baltimore		21218	
Baltimore,	Pages 1 nent of H ant: If Ite ury or ot	0.5	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ I  4 □ Donation 5 ▼Other (Specify,	Removal from State	ce)	Date	20c. Location	- City or Town, State			
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	_	$\vdash$	23a. Part Enter the disease, or comp shock or heart failure. List only of	lications that caused the		lltimore, or the mode of dyin			rest,	Approximate	
1	Physician			ne cause on each line.	/ 1		A			Approximate Interval Between Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	26							
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	uted d ansit	Examiner	Cognostic liet anaditions	b. Due to (or as a consequence of):							
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68760,	ficate be executed physician and is the buriel-transit	Physician/Medicai	Cause (Disease or injury thet initiated events resulting in death) Last	c	to (or as a consequ	ence of):					
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s, P.O	res that the de signed by the a be deteched t	by Ph	Pepti	i ulu	e Di	reasi		101	res 2□ No	3 □ Probably 4 □ Unknown	
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	To the Hospital or A within 24 hours efter To the Funeral Direction completely filled in b	edical C	29a Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge deeth nination and/or inve	occurred at the time estigation, in my op	e date and place inion, death occu	I , and due to the e urred at the time, d	ause(s) and ma late and place, a	nn or all clated. and due to the cause(s)	
	omple	M W	29b. Signature and title of certifier	and marrier states.		29c. License	number	2	9d. Date signed	d (Month, Day, Year)	
	- s - o		N. 211411	m		1) 5	754-	1	9-30	-0%	
•		1	30. Name and address of person who co		(Item 23a) (Type. P				, 39	- 0	
			P. SANDHU, m	4	0 W./	ALTIM	un E J	T. BA	LTIN	DAE 1502122	
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	Registr	ar	DEC 2 2 200	JO KAR SALL	AS ALSON	- Contraction of the Contraction					

Amend item#10e,12,19b, perFh, C350,12/27/05 TI Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygique 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ANTHONY JONES 1302 M 2005 DEC 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MANJUMO MEDIAL CENTER N/A BALTIMORE 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, OCT: 05, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 423-88-108 1 M 2 ☐ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. 10h Counts 10c. City, Town or Location al Hygiene. Jother then "natural", or items 23a or 28a-f show went. Its Medical Exeminar mat be notified at 10a State 10d. Inside City Limits MARYLAND PRINCE GEORGES CO 1 Tyes 2 No Director LENDALE 10e. Street and Number 10g. Citizen of What Country? Martin AVENUE Completed by Funeral 1000 TON 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced BLAC 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VR5 CHRYSLER FINANCIAL CORP. STATE traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked HARLIE ပ္ DOROTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route) Number, City or Town, State, Zip Code) Health a TONES 10000 HORTON AVE VALERIA GLENDALE HO. other Itam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if its
eny injury or ot 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY 12-28-05 MONTGOMERY ALABAMA 4 ☐ Donation 5 ☐ Other (Specify) GREENWOOD BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility while, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death METASTATIC RENAC CELL CARCINOMA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit or Attending Physician: The law requires that the death certificate be executed burial-t Due to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medicai as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical examiner?

Yes 2 □ No Medical Certification; To Be 26. Place of Death | Check only one Hospital: Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Janner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide hours after To the Hospital within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dec, 20, 2005 IMP. ddress of person who completed cause of death (Item 23a) (Type, Print) PAUL GUSTAV KELETZ MD 1417 Ankhoa ST 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State DEC 2 2 2005

Registrar

			For State Registrar	State of Ma		Department of Certificate of			ene 2005	41312
	Dhyaiai		1 Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		hobeet.	JUCKSO	N	) R.		December	21, 200	
	Examin	er	4a. Facility Name (If not institution, gi	_			or Location of Dea	th	4c. County of Dea	th
	E		Bon Secours Hosp 5. Social Security Number 6.	Sex 7 Ag	e (In yrs. last birt		1timore	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director			<b>X</b> 2□ F		Yrs. Months Days	Hours Min	.   (Month, Day, 1	(ear) Co	ountry)
	σ		216-52-2899 Usual Residence of Decedent					1.703713	1.5	
	anylan Phow	_	10a. State 10b. County		10c. City, Towr					10d. Inside City Limits
	Ba-f	Director	MD n/a		Balt	imore				1X Yes 2 No
	Nor 2		10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	ountry?
	se 23	erai	2710 Elliott D	rive	Ever in IIS	13. Was Decedent of	Hispanic Origin?	Specify Ves or No-	USA 14. Race - Ame Black, Whit	arican Indian
40	fter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cu	ban, Mexican, Pue	rto Rican, etc.)	1	
930	al', o	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XN	Specify:		Specify: B1	ack
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anc	od be f	Be							•	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental aumatic event, the Mental aumatic event.	ဥ	Robert Jackson 19a. Informant's Name/Relationship		19b.	Mailing Address (Stree		an Jacks		Zip Code)
Σ	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hyglene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Wedical Examinar must be rediffed at		Corey A. Jacks	on/Son	4	102 Apple	Orchar	d Ct Su	itland	Nd 20746
ē,	permit. Pages 1 and 2 Department of Health Important: If Item 27 eny injury or other tr. once.		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other pi			c. Location - City or	
altimore,	Pages nent of int: if its iry or o		1/1 Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec			us Mam Da	rk 12	/27/05	Anhutus	51.4
alti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lice	nsee		22. Name and Add	ress of Facility W V	lie F/H	PA of	Balto. Co.
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8760, <sup>©</sup>	Physicien and /Medical Examiner sthe paralitransit sthe paralitransit sthe paralitransit states and paralitransit states	ai Examiner	23a. Part1. Enter the disease, or cor shock, or heart value. List only Immediate Cause (Final disease or condition resulting in death)  3-quentially list curruitors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Example Due to (or as Due to (or as	a consequence of a cons	ot): + See helow		ty Hype		Interval Between Onset and Death
P.O. Box 687	Physician: The law requires that the death certificate this certificete has been signed by the ettending physial director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 Ectopic pregnan 5 Other (specify)	су		23d. Date of de Month	ivery Day Year
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£	Physic this o	၉	XXYes 2 □ No	Hospital:	4444	thatterit 3 DOX		Home 5 ☐ Residen		cify)
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<u>&gt;</u>	after Dire	ertil	4 Homicide determined	building, et	(Specify)	ini, street, ractory, omo	•	City or Town.		aran noute number.
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis of and manner st	examination and	, death occurred at the d/or investigation, in my	time, date and place opinion, death occ	e, and due to the cau curred at the time, dat	se(s) and manner as and place, and due	s stated. to the cause(s)
	vithin Fo the	Me	29b. Signature and title of certifier			29c. Licer	nse number	290	d. Date signed (Mont	h. Day, Year)
	/		I headen i	1. 7/10	- MA		O.C.M.E.	De	ecember 22	2, 2005
	5		30. Name and address of person who	completed cause de	eath (Item 23a) (	Tyge Print) II Penn St	reet, Bal	timore, Ma	aryland 21	201
- 2	Sta		31. Date filed (Month, Day, Year)		ar's Signature			-		
	Registr	ar	DEC 2 2 201	D5 /	· At	fired				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roy Jackson 4 56 A M DELEMBER IS 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 10–12–1928 6. Sex Birthplace (State or Foreign
Country) **Funeral** 15€M 2□ F Days Hours 096-48-1498 Director Trinadad Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examinat must be notified at once. 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 √es 2 No Director N/A Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4231 Loch Raven Blvd 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Newton Jackson Estella Jack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 W. Fayette Street Baltimore, Maryland 21223 Casnell Jackson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 12-21-2005 Trinity Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wise Funeral Services, P.A. 21. Signature of Funeral Service Licensee 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed PROSTATE CANCER METASTATIC Due to (or as a consequence of): Completed by Physician/Medical UROSEPSIS 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE RENAL 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner?

N ✓ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA ŏ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 Stuti Shankar MD DECEMBER 15 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD , BAUTIMORE, MD

Registrar DHMH 17 Rev 1/2001

State

LOCH RAVEN

SHANKAR

31. Date filed (Month, Day, Year)

,5601

32. Registrar's Signature

				ype or Print in Blac			•		
			For State Registrar	State of Maryland / [	Department of H Certificate of I			ene2005 413	14
	Physicia	an	Decedent's Name (First, Middle, Last)	FALL VAC	ALCO ET	2	. Date of Death Month	Day Year 3. Time of D	A
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	Funeral Director		11-14-6767	M 2 F 7. Age (In yrs. last bir	Yrs. Months Days	Hours Min.	(Month Day	9. Birthplace (State or Country)	Foreign
	yland		Usual Residence of Decedent  10a. State  10b. County	10c. City, Tow	n or Location			10d. Inside City	-
	the Mar	Funeral Director	10e. Street and Number	ELK	10f. Zip Code		10	1 ☐ Yes 2	2 🛮 No
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	items	uner	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci n, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.	
900	d within 72 hours after death with the Maryland piene. r than "natural", or Items 23a or 28a-f show the Madical Evartinet rust be motified at	by	3 ■ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1□ Yes 2☑ No	Specify:		Specify: WHITE	<u>.                                    </u>
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and	be be eve	To Be	17. Father's Name (First, Middle, Last)	SOYKE		18. Mother's Name (	First, Middle, Mi	ASTER Sumame)	
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Baltimore,	mit. Pages bartment of ortant: If it injury or o		1  Burial 2  Cremation 3  Re 1  Donation 5  Other (Specify)	emoval from State  BLA	ry, crematory or other place	11//	105 E	SEL AIR ME	)
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al Re		Com					autopsy performe	ed? death?  Yes 2 No	
ſ Vit	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☑Inpatient 2 ☐ ER/Ou	utpatient 3□ DOA Oth	26. Ptace of Death ( er: 4 ☐ Nursing Home		ce 6 ☐Other (Specify)	
o uc	ling I. After Tune	1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of 28c. Injury Work	y at 28 k? Yes 2 □ No	ld. Describe how	injury occurred	
Division	tan eat or: the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			f. Location (Stre City or Town,	eet and Number or Rural Route Number State)	9 <i>r</i> ,
۵	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	e, death occurred at the tin	ne, date and place, an	d due to the cau	use(s) and manner as stated.	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examir one)	er: On the basis of examination an and manner stated.	nd/or investigation, in my o	pinion, death occurred	at the time, dat	e and place, and due to the cause(s)	
	To with	~	29b. Signature and title of certifier	MD	29c. Licenson	1398		d. Date signed (Month, Day, Year) ECEMBEL 20, 20	05
	10			GI, MD UI	(Type, Print) H	OSPITAL	EL	KTON, MD.	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 20	32. Registrar's Signature	Come				
					6				

Please Type or Print in Black Indelible Ink.	<b>Ensure All Copies Are Legible</b>
0.1. (1411/5)	111 1 1 1 1 1 1 1 1 1

			1 - For State Registrar	ate of Maryland		rtment of H tificate of I			ene 2005	41315
	7	187	Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medio		Hui Chang Kwon						Day Year	
	Examir		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
	Funeral Director	47	5. Social Security Number 6. Sex 157 M 6	7. Age (In yrs. las	et birthday) Yrs.	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		rthplace (State or Foreign ountry)
			Usuel Residence of Decedent					qualiter.	14, 1929 N	orea
	how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Ma	g j	Maryland Carroll	Syke	svill	е				1 ☐ Yes 2 🙀 No
	ith th	Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen ol What C	ountry?
	23a		12825 Forest View Ct.			21784			U.S.A.	
	tems	Funeral	A	as Decedent Ever in U.S. med Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto F	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
36	orl	by Fi		☐ Yes 2 📉 No Yes, Give	1	☐ Yes 2√2 No	Specify:		Specify:	
215-0036	72 hours after death with the Maryland natural', or liems 23a or 28a-1 show dical Examinar musi be notilied at		3 ₩ Widowed 4 □ Divorced Ÿ  15. Decedent's Education	ear or Dates:	16a Dagad	ent's Usual Occupa	ation	14	6b. Kind of Business	Asian
5	n 72 n *na n *na	lete	(Specify only highest grade com	pleted)	(Give I	kind of work done of ONOT use retired	during most of workin	g	ob. Kind of Business	sindustry
212	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+) 4	Owner		,	K <sub>1</sub>	won's Trad	ding Pro
	be filed within 72 hours after death with the Manyian Ital Hygiene. ed other than "natural", or Items 23s or 28a-f show event, the Medical Examinat must be notified at	BeC	17. Father's Name (First, Middle, Last)		0		18. Mother's Name			aring 110.
Maryland	should be and Mental I marked o	To B	Ki Sang Kwon				Sun Hee	Tee		
ary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, P	rint)	19b. Mailin	g Address (Street a	and Number or Rural		City or Town, State,	Zip Code)
	1 and 2 Health a em 27 is		Hong Pak- son-in-law		12825	Forest V	liew Ct.,	Sykesvi]	lle, MD 2	1784
altimore,	item		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of atory or other plac	Da		Oc. Location - City or	
E	Pages nent of I ant: If it		ty☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	•		ens 12/23/	2005 Da	avidsonvi	lle MD
	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		22.	Name and Address	s of Facility		IV EGBOITV E	iic, iii
Ω	88558		Mapa		W. 5	itzke Fur 555 Twin	neral Home Knolls Rd	s, INC	nbia MD 1	210715
S E	Priysician		23a. Part1. Enter the dispase, or complication shock, or heart failure. List only one cau Immediate Cause (Final	use on each line.	Do not ente	r the mode of dyin				Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	LUNG CA						
	Examiner									
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):					
V	icate be executed physician and s the burial-transit	Examine	that initiated events							
90,	e exe ian a urial-	Ě	resulting in death) Last	Due to (or as a consequer	nce ol):					
68760,	the the	edical	d							
		/Me	IF FEMALE:	yes, outcome ol pregnanc						1
Вох	eath certifi attending for use as	Physician/M	in the past 12 months?	ULive birth 2 □ Fetal de □Pregnant at time of deat	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
P.O.	by the destached	ysic		Unknown	ui 5	Other (specify)				
	that sed by deta		Part II. Other significant conditions contribut	ing to death but not resulti	ng in the un	derlying cause give	en in Part I.	23e. Did toba	.cco use contribute t	o the cause of death?
of Vital Records,	The law requires that the death certifule has been signed by the attending tage? should be detached for use a	d by						10 Yes	2 □ No 3 □ P	robably 4 Unknown
S	w require been sign should b	Completed				-		24a. Was an	24b. Were a	utopsy lindings available
Re	he la e has age 2	шc						autopsy performe	prior to death?	completion of cause of
ta		a	25. Was case referred to medical				26. Place of Death			s 2 No
5	Physiclan: this certifica ral director, p	0.0	examiner? 1 ☐ Yes 2 ☑ No Hospit	al: 1 ☑npatient 2 ☐ EF	R/Outpatient	3□ DOA Othe			ce 6 □Other (Spe	acutu)
0		n.			8b. Time of	28c. Injury Work		d. Describe how		Scriy)
Ö	Attending I r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16al)	Injury		Yes 2 □No			
Division		tifle	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	- 28	I. Location (Stre City or Town,	et and Number or R	lural Route Number,
Ö	tal or rs afte al Diru ed in t	Certification:		banding, etc. (opcony)				ony or roun,	Sidiey	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only 2   Medical Examiner: C	To the best of my knowled the basis of examination and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my of	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
			beleku kassah	10 M.1	٥.	500	55973	7	erember	20,2005
	1	- 9	30. Name and address of person who complet	011		Print)		,,,		
			Zeleice Desse 1	1500 Suthe	rland	+ hill	way Si	Irer St	oring N	20,2005 1D 20904
4	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	9					
	Registr	ar	DEC 2 2 2005 🎉	Bracks St. Pos	conse	la.				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20, Year 2005 **Physician** Month KARL STEES December 8:00 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8709 Crystal Rock Lane Laurel Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Apr. 21, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign XXM 2□ F Director 221-34-7707 57 Yrs Apr. I'948 Delaware Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location Item 27 is marked other than "naturel", or Items 23a or 28e-1 show other treumetic event, the Medical Exam ar must be righted at 10d. Inside City Limits Director Prince George's 1 ☐ Yes 2☐No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8709 Crystal Rock Lane 20708 death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Hygiene. Black, White, etc. 1 ☐ Yes 2 XXX If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 📉 No Completed by Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Computer Scientist Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis J. Klein 2 Priscilla Stees 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is an any injury or other treum once. Diane H. LaPorte spouse 8709 Crystal Rock Lane Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XXremation 3 ☐ Removal from State West Arundel Crematory 12/22/05 ' 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. ≠ M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dilated Cardiomyopathy disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably **₹**IXUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 TYNo 24a. Was an page 2 s has autopsy performed? certificate Division of Vital 1 Yes 2 X X0 XXNo Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Certification: To 1 ☐ Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospitel or Attending 1 XNatural 5 Pending death. investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in within 24 hours a 29a. Certifier to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of 2 29c. License number 29d. Date signed (Month, Day, Year) 142110 December 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard Griffen, III, M.D. 7350 Van Dusen Rd. #410 Laurel, Maryland 31. Date filed (Month, DEC 2 2 32. Restrar's Signature State 2005 Registrar

			For State Registrar	State of Marylan			ealth and M		7905	41317
	_		Registrar  1. Decedent's Name (First, Middle,	( ast)	Cerui	icale of L	Jealii	2. Date of Death	Ño.	3. Time of Death
	Physici		GLADY	S King					Day Year	
	/Medic Examir		4a. Facility Name (If not institution,	give street and number)	46	. City. Town. or	Location of Death	DEC: 10	4c. County of Death	5:00 A M
	Exami	iei.	HAVKID	NURSING /	FIME	2017	MONE		N//	1
	Funeral		5. Social Security Number	5. Sex 7. Age (In yrs.		Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	Director		218-22-4212	10 M 20 F 78	Yrs. M	onths Days	Hours Min.	Month, Day, Ye	ear) Cou	MD.
	p ,		Usual Residence of Decedent	1000						
	anyla shov	_	10a. State 10b. County	100. CIT	y, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ecto	1/1D	11 06	ALTIME	· -				
	with with	<b>Funeral Director</b>	10e. Street and Number	HURST AUS	_	Of. Zip Code	,	10g.	Citizen of What Cou	intry?
	eath	eral	11. Marital Status	12. Was Decedent Ever in U.	S 13 Was	Decedent of Hi	15 enanic Origin? (Spe	cifu Voc or No	14. Race - Ameri	7 ·
"	r Iten	Fun	1 □ Never Married 2 □ Marrie	Armed Forces?	If Ye	s, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto I	Rican, etc.)	Black, White	, etc.
036	el', o	by	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 22 No	Specify:		Specify: 19	4,75
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-1 show Iteal Examiner could be mailled at	Completed	15. Decedent's (Specify only highest	Education	16a. Decedent	s Usual Occupa	tion	166	. Kind of Business/Ir	ndustry
7	within iene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	11	1/	uring most of worki		11	
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Items 23e or 28e-f show other the Madral Extra or or 18 be or orlifed at		NA		HOME	MAKE	=12-		own Hi	ME
Maryland	t be find He of other sever	Be	17. Father's Name (First, Middle, La	F. BENTON				(First, Middle, Main	den Sumame)	
Ž	d 2 should by th and Menta 7 is marked treumetic ev	<sup>2</sup>	19a. Informant's Name/Relationshi		10h Mailing A	ddroop (Etmat a	EMMA		ty or Town, State, Zij	- 0-4-)
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ē	s 1 and if Healt item 2 other		20a. Method of Disposition	20b. P	lace of Dispositio	n (Name of	D	ate, 200	. Location - City or T	own, State
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			23a. Part1. Enter the disease or c shock, or heart failure. List or	omplications that caused the death	h. Do not enter th	e mode of dying	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):				-	
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T	ed isit	ine	cause. Enter Underlying Cause (Disease or injury	Due to for as a conse in	uence of):					
Λ	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	ical E			· ·					
Ö	ifficati g phy as the	edic		U						
Вох	h cert endin use	/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal					23d. Date of deliver	өгу
	deat	sicle	in the past 12 months? 1 \sum Yes 2 \sum No	4☐Pregnant at time of de		opic pregnancy ner (specify)			Month	Day Year
P.O.	The law requires that the death certific lie has been signed by the atlending p bage 2 should be detached for use as	Physician/Med	9 Unknown							
	res th	by	Part II. Other significant condition  Demenheir	s contributing to death but not resu	uiting in the underl	lying cause give	n in Part I.		o use contribute to t	
oro	w require been sig should b	eted	Dement-					1 L Yes	2 No 3 Prot	pably 4 Dunknown
Vital Records,	has the	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
alF	Phyeician: The k this certificate ha ral director, page 2							performed 1 ☐ Yes 2 ☑		212/No
Ξ	eiciar certif recto	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		Othe	26. Place of Death			
of	Phy ar this aral d	: To	27. Manger of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	4 Le Nuising Hon	1e 5 ☐ Residence 8d. Describe how in	6 ☐Other (Specif	(y)
ion	Attending Physician: r death. sctor: After this certifics by the funeral director, g	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury M		? es 2 □ No		,-,	
Division	er degeneration	Certification:	3 Suicide 6 Could no determin		ome, farm, street, i	actory, office	2	8f. Location (Street City or Town, St	and Number or Rura	Al Route Number,
	ital or rs afte el Dire	Cer								
	Hosp 4 hou Fune ely fil	edical	(Check only Z   Medical C	Physicien: To the best of my know aminer: On the basis of examinat	wledge, death occ	urred at the time	e, date and place, a	nd due to the cause	e(s) and manner as s	tated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	one)  29b. Signature and title of certifier	and manner stated.		29c. License			Date signed (Month,	
	5 7 ½ ± 3			d		P304			Date signed (Month,	Day, Iddi)
	,		30. Name and address of person wh	o completed cause of death (Item	23a) (Type Brins		,			
			* DESAIND	716 Maicleuche		,	I timore	STRIB CIN	3	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat		-				
	Registr	ar	DEC 2 2	2005	Angel	20				

DHMH 17 Rev 1/2001

			For Stete Registrar	State of N	Maryland / Dep Ce	artment of I			giene 05	41318
			Decedent's Name (First, Middle)	, Last)		·		2. Date of Dea	ath	3. Time of Death
	Physici		Damiibhai	v.	Kathrotiya			Decembe	Pay Year 20, 200	
	/Medic Examin		4a. Facility Name (If not institution,				or Location of Dea		4c. County of De	
		ei	104 Sharon Cour			Lau	_			George's
	Funeral				4 Age (In yrs. last birthday	-	If Under 24 Hrs	s. 8. Date of Birth		
	Director		212-08-7939	1 <b>X</b> M 2 □ F	67 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day  Dec 25,		irthplace (State or Foreign Country) India
	ס		Usual Residence of Decedent					Dec 23,	1757	India
	ylan		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f s	iç	Maryland Prince	e George's	L	aurel				1 ☐ Yes 2 🛣 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
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	dea	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.			Specify Yes or No- rto Rican, etc.)		nencan Indian,
ထ	or the		1 ☐ Never Married 2XXMarrie		No	1 ☐ Yes 2 🛣 No		nto mican, etc./		ite, etc.
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates			ороспу.		Specify:	White
Š	72 h	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	(Giv	edent's Usual Occur s kind of work done	during most of wo	orking	16b. Kind of Busines	s/Industry
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S .	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23e or 28e-f show atto event, the Modical Exertinar roast by notified at	Be	17. Father's Name (First, Middle, L					me (First, Middle,		
Maryland 21215-0036	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. I flem 27 is marked other than "natural", or flems 23a or 28a-1 show rether traumatic event, the Madical Exercitival real by notified at	1º	-	athrotiya			Mani		Ghatiya	
<u>a</u>	12 st h and 7 ts n traun	a i	19a. Informant's Name/Relationsh						r, City or Town, State,	
a)	1 and 2 Health tem 27 other tra		Yashwant Kathro 20a. Method of Disposition	tiya/son	20b. Place of Disp	Fox Cre	ek Court	Cooksv	ille, Mary	
altimore,	Pages 'nent of H		1 ☐ Burial 2 X Cremation	3 □Removal from Stat	e cemetery, cre	matory or other pla	·		20c. Location - City o	
	tmen tant:		`4 □Donation 5 □Other (Sp						Odenton,	
Ba	permit. Pages Department of Important: If I any injury or oue.		21. Signature of Funeral Service L	00	3	2. Name and Addre Donaldson	ess of Facility Funeral	Home & (	Crematory,	P.A.
_	40 = 6 d		Juanita K	thomas	M00957 1	411 Annap	olis Roa	d Odento	on, Maryla	nd 21113
Ų,			23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that caus only one cause on each	ed the death. Do not er line.	ter the mode of dyi	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
N	Physician		Immediate Cause (Final disease or condition	a Metast	atic Cance	r of unkn	own prim	ary site		Onset and Death 3 months
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of):					-
8	Examine	L	Sequentially list conditions, if any, leading to immediate	b						
7	ad sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					
V	and -tran	Examiner	that initiated events resulting in death) Last	C. Due to /or a	is a consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	ai E	, , , , , , , , , , , , , , , , , , , ,	Due 10 (01 a	is a consequence or).					
	cate physic	dicai		d.						
9 ×	ding I	/Me	IF FEMALE:	23c. If yes, outcom	o of prognancy		7-111-17			
Вох	eath certific attending p for use as l	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
o	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death 5	Other (specify) _				
٦.	that II	P.	Part II. Other significant condition	ns contributing to death	but not resulting in the	inderlying cause on	ven in Part I	23e Did to	bacco use contribute	to the cause of death?
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115	ysiclan: The sister of the director, pages	Be	25. Was case referred to medical examiner?	11				ath (Check only on	18)	
10	this o	P	1 ☐ Yes 2 💢 No		tient 2 ER/Outpatie	nt 3 DOA			ence 6 □Other (Spi	ecify)
ב	ding Ph h. After th funeral	OU:	27. Manner of Death 1   Natural 5   Pending	28a. Date of In (Month, D	jury 28b. Time ( <i>Day Year)</i> Injury	Wo		28d. Describe ho	ow injury occurred	
<u> </u>	Attendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could no	ot be			Yes 2 □ No			
Division	or At fter d irect irect n by	Certification;	4 Homicide determine	ned   286. Place of I	njury - At home, farm, si etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town	treet and Number or A n, State)	Rural Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		V					1		
	Hosi 24 ho Fune tely fi	edicai	(Check only 2 Medical E	xeminer: On the basis	st of my knowledge, dea of examination and/or in	th occurred at the ti	me, date and plac opinion, death occ	e, and due to the caured at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
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	5 ± 5 0 0		29b. Signature and title of certifier	MD				2	9d. Date signed (Mon	
	/		· · · · · ·				715		December	20, 2005
	Á		30. Name and address of person w			•	1.0.1	770 5 5 5		MD 00710
	1		Chitra Venkatr 31. Date filed (Month, Day, Year)		6201 Gree:	nbelt Roa	a Suite	U3 Colle	ege Park,	MD 20/40
	Sta Registr		Jr. Date med (World, Day, 1981)	32. negis	-	P . N .				
	negisti	ч	DECSS	2005	H. A					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item I per doc 9850 12-22-05 vt.
State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month akins Ward 3 05 2:50 PM /Medical 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimure
If Under 1 Year If Under 24 Hrs. 8 hearn - OC re 6. Sex. 1 M M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 197-22-8040 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ? ie marked other than "natural", or Itema 23a or 28a-f ehow traumatic event, the Medical Examiner must be motified at 10d. Inside City Limits WI Director 1 Yes 2 □ No Honore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5817 21215 venue Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No It Aes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race -American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mprovement ather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental Pages 1 and 2 should be ق Cober 19b. Mailing Judress (Street and Jumber or Rura) Route Number State, Zip Code) 20b. Place of Disposition (Name of Cometery, cremator of other) arrance 20a. Method of Disposition ō <u>=</u> 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) ö 3 Removal from State Department in important: if any injury or once. Darrison 21. Signature 81133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Endstage Alzheimer **Physician** demontes /Medical Due to (or as a consequence of): Examiner ros7 9710 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Anorexia Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Completed 2 No 1 Tes 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed certificate 1 Yes 2 No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 KNo this 3□ DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury death. М 1 ☐ Yes 2 ☐ No ∑ 🔲 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral [ To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ohiokpehai, mo 2600 LISERY HUT AVE BAILY MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State BEC 2 2 2005 Book Registrar

			1 - For State Registrar	State of Marylar		epartme Certifica			-	giene	1111	41320
一卷			Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	Physici /Medic			Deborah	L	Moore	9		12			
	Examin	N	4a. Facility Name (If not institution, give s					Location of Dea	ith	4c.	County of Dea	ath
150			SAINT AGNES, HO		t4 b '-4		er 1 Year	Mone 24 Hr	0 10 5 . (5)			/ A
	Funeral Director		5. Social Security Number  213-54-2405  Usual Residence of Decedent	7. Age (In yrs.		Months		Hours Mir		iy, Year) , 19	64 M	rthplace (State or Foreign ountry) aryland
	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23a or 28a-f show the Mudical Exachinar most ke notified at		10a. State 10b. County	10c. Ci	ty, Town	or Location						10d. Inside City Limits
	Mar illing	tor	MD Baltin	nore		Halet	hor	pe				1 ☐ Yes 2 No
	or 28	by Funeral Director	10e. Street and Number			10f. 2	ip Code			10g. Cit	izen of What C	ountry?
	23a	lai	2208-B Hammond	ls Ferry Ro	ad			21227			USA	
	tems	nue		12. Was Decedent Ever in L Armed Forces?	I.S.	13. Was Dec	edent of H ecify Cuba	ispanic Origin? ( in, Mexican, Pue	Specify Yes or No irto Rican, etc.)	)-	<ol> <li>Race - Am Black, Whi</li> </ol>	
36	s afte	y F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 🗆 Yes	2[ <b>X</b> No	Specify:			Specify: LT	hite
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15	in 72 n "ng n "ng	piet	(Specify only highest grade	completed)		Give kind of v life. DO NOT	vork done i	durina most of w	orking			a modely
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٦	e file al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle			
<u> a</u>	Ments Ments wrked	ToE	Russel	.1 Strecke					Lydia		Unk.	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The most second the than "natural" or liems 23a or 28a-f show any njury or other traumatic event, the Medical Examinat must be notified at another.		19a. Informant's Name/Relationship (Ty)	· · · · · · · · · · · · · · · · · · ·								Zip Code) 32224
≥	and ealth m 27		Paul R. Moore,						-			Beach, FL
o o	ges 1 t of H if ite or off		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	ettiovat ilotti State		Disposition (N r, crematory or		1	Date	20c. Lc	ocation - City o	r Town, State
ቜ	tmen tant:		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)					Inc. 12/				re, MD
Baltimore,	Department of the post of the		21. Signature of Funeral Service License	me George Mach	labb	Cren	and Addre	Sn Soci	ety of	Mar	yland	, Inc.
100			23a. Part1. Enter the disease, or compli	cations that caused the dea	th Do g	299	Frec	ierick	Road I	Ralt	imore	MD 21228 Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.				g, odori do odran	ac or roophatory a	11031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	HEDATIC			E					MENKHOWN
	Examiner			Due to (or as a consec HEPATI		•						CONTRACTOR OF THE PARTY OF THE
3		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec			AN	0				UNGNOWN
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8760,		cai										
89		Physician/Med	IF FEMALE:									
Вох	death certifica e attending ph ed for use as th	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		3 □Ectopic	pregnancy			1	23d. Date of de Month	
	e dea the at	sici	in the past 12 months? 1 □ Yes 12 □ No 9 □ Unknown	4☐ Pregnant at time of of 9☐ Unknown	death	5 Other (	specify)				Month	Day Year
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Vital Records,	sicla certi irecto	) Be	25. Was case referred to medical examiner?	lospital: Inpatient 2	I EDIO		Oth Oth	05	eath (Check only o		- Cau (a	
ō		. To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Ti		28c. Injun Wor	4 🗆 Ituraling	Home 5 Resi			ecity)
on	th. : Afte	tio	Natural 5 Pending investigation	(Month, Day Year)	In	jury M		k? Yes 2∐No				
Division of	I or Attsnding after death. Director: Aftel I in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, fari fy)	m, street, facto	ory, office		28f. Location ( City or To			Rural Route Number,
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the t	edical Co	(Greck only 21 Medical Examili	sician: To the best of my kniner: On the basis of examin	owledge, ation and	death occurre	ed at the tin	ne, date and plac pinion, death occ	! ce, and due to the curred at the time,	cause(s)	and manner a I place, and du	s stated. e to the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.		2	9c. Licens	e number		29d. Dat	e signed (Mon	th. Dav. Year)
	F 3 F 8		13my	M.D.				19513			- 19 . 20	
7	2		30. Name and address of person who co		m 2301 /1	Type Print)	,	1-121				
	)		DR. KEYURKUMAR	BUCH, 900			AV	E, BA	LTIMORI	= 1	ND 21	229
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	arune	P						

MRH 5960875535 OK/NG

MODRE, DEBBIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 

Madden Danche December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital City Baltimore Sinai Balhmore If Under 1 Year | If Under 24 Hrs. 200 7. Age (In yrs. last birthday) 5. Social Security Number 212-22-8265 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours ac 1 □ M 2 💢 F APRIL 12,1910 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "neturel", or items 23s or 28s-f show traumstic avent, the Medical Executer must be notified at ma Directo 10f. Zip Code 10e. Street and Number 3939 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Blanche 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 Xvo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Coth e ma Known as 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h permit. Pages 1 and 2 should be Deportment of Health and Mental Important: If Item 27 Is marked any injury or other traumatic avonce. newton NeaL ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarks Bacto, md, 3737 heice Delices Jehnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 28 Battemine Not's Com 21. Signature Funeral Service Licensee 22. Name and Address of Facility 270 Fred the Ton Pa Gery Pimarch Funeral Home Party Egree the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypovolenna **Physician** /Medical Due to (br as a consequence of): Examiner Gastrointestinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed Memstatic Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Be Completed 24a. Was an autopsy performed certificate 2 No 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) Medic

3. Time of Death 1:50 PM 2005 4c. County of Death NIA Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Nes 2 No 10g. Citizen of What Country? 14. Race - American Indian. Black, White, etc Black 16b. Kind of Business/Industry Domestic MORD 20c. Location - City or Town, State mo. Bacto, md, 2,229 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Hospital of Baltimore

December 17, 2005

State

Canjani 31. Date filed (Month, Day, Year) DEC 2 2 2005

29b. Signature and title of certifier



dijan Ramaraltar MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramarathan

RES - 000

Registrar

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 48 A. M 1)60 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner silchri enter 10WSOr HUT MORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 9-725 10 M 20 F Months i Days Hours Min 215-0 102 Yrs. Director NEW Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Completed by Funeral Director imonium SAUTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or other traumatic event, the Medical Examiner must be USA 21093 12021 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mgther's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental bernar 100 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar important: if item 27 le eny injury or other trau Limonium MD 21093 12021 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Cometer 22. Name and Address - Facility 21. Signature of Funeral Service Licentsee EVAILS FUNERAL CHAPEL 8800 HARFORD RD MO 21234. 10 TKL 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. n. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 500 Vascular 4 cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical ate has been signed by the attending physipage 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1 Yes 1 Yes the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence SCOther (Specify) N 0 50 ( Eq Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Certification: To 3□ DOA 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide o the Hospitai 29a. Certifier ACC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

48AM

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 2 2 2005

RODON CHARLES

31. Date filed (Month, Day, Year)

m coop M. Chance

32. gistrar's Signature

D28303

Towson, mo

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			For State Registrar	State of Ma	ryland		artmen tificate			and Me		giene Reg. No.	05	41323	
	Physici	an	1. Decedent's Name (First, Middle, Last)	W - C C - L L						2	<ol><li>Date of De Month</li></ol>	ath Day	Year		
	/Medic	al	Robert E.				4h Cihi	Tour or	I continu	f Dooth	DEC	20	200	•	
	Examin	er							vn, or Location of Death				4c. County of Deeth		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last		If Under	1 Year	If Under		B. Date of Birt	th	9. Bi	rthplace (State or Foreign	
	Director		220-18-7749	M 2 🗆 F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da May15	, 19:	26 Mar	yland	
	P >		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits	
	sho	ក	MD Baltimo		TOO. ONLY, I	Ess								1 ☐ Yes 2 🛣 No	
	28a-1	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10.	10f. Zip	Code				10a, Citiz	en of What C	ountry?	
	leath with the Marylan ns 23e or 28a-f show met be rediffed at	٥	416 MAryland A	ve.			1.4.1.	212	21			USA		,-	
	ms 2	Funeral		12. Was Decedent Ev	ver in U.S.	13. \	Vas Deced			gin? (Spec	ify Yes or No ican, etc.)		4. Race - Am	erican Indian,	
9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	)				Specify:	i, ruerio ni	ican, etc.)		Black, Whi		
Maryland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic event, the Medicul Exa	Be Completed by	3 Widowed 4 Divorced		Δ						Specify White				
15-			15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)						urina most	g most of working				of Business/Industry	
12			Elementary/Secondary (0-12) College (1-4or 5+)  8th  Locksmith							KleineAutoWorks					
br			17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (	First, Middle,	Maiden S	Sumame)		
/lar		ToE	Ellsworth Moff	ett					Mar	gare	t Beg	ıgs			
lan			19a. Informant's Name/Relationship (Ty										Town, State,	Zip Code)	
	of Health Item 27 other tra		Patricia Kocur  20a. Method of Disposition	/daughte			Kitt sition <i>(Nam</i>	1700	ourt	. For	est H		MD 2 ation · City or	1050	
Jor	00		1 Burial 2 Cremation 3 F	emoval from State	cem	etery, cren	natory or of Cren	ther place			2/05			re MD	
Baltimore,	permit. Pag Department Importent: I any injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	ne (7)	0./		. Name an			v					
Ī			1 K Tessay	(032 0	11/	4				Cor				omeofEssex	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death—to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
			Immediate Cause (Final disease or condition	Chih	1	al-	13	A	culit					Onset and Death	
			resulting in death)	Due to (or as a	consequer	nce of):	77.6	~ ,	- La 1	12					
		Sequentially list conditions, b.													
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):													
-5	be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	Due to (or as a	consequer	nce of):									
8760,	ate be ex hysician the buria	dical	L.	l											
9	tificate ig phys as the	by Physiclan/Medic													
Вох	icien: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burnal-transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							23d. Date o			delivery Dav Year		
		sicl	1  Yes 2 No 9 Unknown S Unknown							Month Day Year					
P.0		Phy							23e. Did tobacco use contribute to the cause of death?						
Vital Records,			1 🗆 Y							101	1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐Unknown				
COL		se Completed								24h Were autonsy findings available					
Re											autop	rmed?	death?	utopsy findings available completion of cause of	
ta			25. Was case referred to medical						26. Place	of Death (	1 Yes Check only o	2 <b>/2</b> -No	1 🗆 Ye	s 2 No	
f Vi	dilis	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Mnpatien	t 2 EP	VOutpatien	t 3 🗆 DO	A Othe					□Other (Spe	ecify)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury		8c. Injury Work	at		28d. Describe how injury occurred				
sio	Attending in death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 🗆 i				A1		
Division	F B F	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home (Specify)	e, tarm, str	eet, factory	, office		28	City or Tov	vn, State)	Number or H	ural Route Number,	
1	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in Incompletely filled in Incomplete		29a. Certifier 1 Certifying Phys	sicien: To the best of	my knowle	edge, death	occurred a	at the time	e, date and	d place, an	d due to the	cause(s) a	ind manner a	s stated.	
	e Hos	Medical		ner: On the basis of e and manner state	examination	and/or inv	estigation,	in my op	inion, deat	th occurred	at the time,	date and p	place, and du	e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	u-			29c	License	number			29d. Date	signed (Mon	th, Day, Year)	
			1/4	7-3				P19	74	9		Da	20	2007	
h			30. Name and address of person who co										,		
Ú			RYAN Kiems M 31. Date filed (Month, Day, Year)	32. B <b>ø</b> gistrar	's Sinn-ti-	68	2ten	9	ST	BA	CAMP	6 p	7 2	201	
	Sta Registi		DEC 2 2 20	05 SZ. Fregistrar	's Signatur	*	mark)	,							
	J		DLU 4 & 4V	A CONTRACTOR OF THE PARTY OF TH	100	/40	-								

Robert ELLS WORTH MAFFETT

			1 - For State Registrar	State o	of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of	lealth and <i>Death</i>	Mental Hyg	iene () ()	5	41324			
	· ·		1. Decedent's Name (First, Middle	, Last)				-	2. Date of Deat Month	h Day	Year	3. Time of Death			
	Physici /Medio		THOMAS	LYI	NCH	MERF	RYWEATH	ER	Decembe	r 18, 2	005	7:10 A M			
	Examin	i	4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, Town, o	r Location of Dea	ith	4c. County	of Death				
			Edward W. McCr					isfield				merset			
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	9. Birthp	lace (State or Foreign			
	Director		220-05-2987 Usual Residence of Decedent		85	115.			May 23,	1920	Mary	land			
	and *		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits			
3	f sho	ō	Marriand Con	norsot			Crisf	i al d				1 ☐ Yes 2 No			
	3a or 28a-	rec	Maryland Son	merset			10f. Zip Code	IGIG	1	Og. Citizen of V	/hat Cour	itry?			
		0	4930 Thomas Lo	na Road				21817			USA				
	ms 2	Funeral Director	11. Marital Status	12. Was Dec	pedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cub			- Americ	an Indian,				
0	riter of the		1 ☐ Never Married 2 🔀 Marri	ied 1 XYes	2 NoWor	ld			no Hican, etc.)		k, White,	etc.			
3	al', o	by	3 Widowed 4 Divorced	If Yes, Gi Year or D	Dates: War	II	1□Yes 2ŽLNo	Specify:		Specify	Wh:	ite			
ָר ה	72 ho	Completed	15. Decedent (Specify only highes		)	16a. Deced	dent's Usual Occup	ation during most of we		16b. Kind of Bu		,			
V	ithin	du	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	d)				aryland			
7	ed w ygier yertt	ပ္ပ	12	<u> </u>		Pro	operty Ma		(F)			atural Resorc			
מום	be til Ital H Id ott	Be	17. Father's Name (First, Middle,	_					ume (First, Middle, I Sullivan		θ)				
yla Y	is rature should be lied within 12 hours after death with the waryan if Health and health and Hygiene. If Health and Markad other than "natural", or Itams 23a or 28a-f show other traumatic event, If a Markad Express contact the colline of all and the c	ည	Edgar Thomas Merryweather  Myrtle Sullivan Henry  19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
Mai					/rz' C \										
<b>.</b>	1 and Health		Shirley A. Merry 20a. Method of Disposition	weather	(WITE)				d - Crisf	20c. Location -					
0	iges or of		1 Burial 2 ☐ Cremation		State	cemetery, crer	sition (Name of matory or other pla	cθ)			•				
	t. Pa ntmen ntant: njury		*4 □Donation 5 □ Other (S)		tas				12/21/05	durtock	, Mai	yrand			
מ	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other <u>ence</u> .		21. Signate (a) Funeral Service Using Service Usin Using Service Using Service Using Service Using Service Using S												
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  PROSTATE CANCER												
F	hysician /Medical Examiner														
			resulting in death)	Due to	(or as a consec		1	011100							
ľ			Sequentially list conditions	b											
	D ≓	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	a to (or as a consequence of):										
	acute Ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	,										
00,	oe exe		resulting in death) Last	. Due to	Due to (or as a consequence of):										
	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d											
0 :	ertific Jing p	Physician/Med	IF FEMALE:	220 Hyan o	utcome of pregn	2004		7.7	Water Transfer	20.0	1.0				
Š	ath c attend for us		23b. Was decedent pregnant in the past 12 months?	Ectopic pregnanc				23d. Date of delivery  Month Day Year							
5	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)												
ŗ	that the	P	Part II. Other significant condition	ons contributing to c	death but not res	sulting in the u	ndertying cause giv	en in Part I.	23e. Did tot	acco use contr	ibute to th	e cause of death?			
ecords,	signe d be	d by	•		BLEET	-	, , ,		1 □ Ye	s 2 X No	3 🗌 Prob	ably 4 □Unknown			
Š	requ been shoul	ete		•	ASCV				240 14500	245.1	Vara auto	nou findings available			
ອ .	elaw has ye2s	Completed			M > C V	1) '		·	24a. Was a autops perforr	у   р	rior to cor	osy findings available inpletion of cause of			
<u> </u>	icate icate r, pag	ပိ							1 ☐ Yes 2	No 1	Yes	2□ No			
\ \ \ \	certif recto	Be	25. Was case referred to medical examiner?	I I a a subali	<u> </u>	2	Ott	00	eath (Check only on						
<b>5</b> i	this raldii	- T	1 Tes 2/200 1/20 Inpatient 2 EMOutpatient 3 DOA 4 Nursing Home 5								☐ Residence 6 ☐ Other (Specify) ascribe how injury occurred				
	After After fune	lo	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury Injury W						Work?  1 □ Yes 2 □ No						
<u>,                                    </u>	death death ctor: / the	lcat	3 Suicide 6 □ Could r	not be	e of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (St	reet and Numbe	er or Rura	l Route Number.			
DIVISION	To the Hospita or Attending Physician: The law requires that the death certific within 24 hours after decort. To the Fundatal Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification;	4 Homicide determ	build	ding, etc. (Speci	oot, lastery, online	City or Town	City or Town, State)							
-	ours naral filled	S S	29a. Certifier 1 🗖 Certifyin	g Physician: To th	e best of my kno	owledge, death	occurred at the ti	ne, date and place	e, and due to the ca	luse(s) and mai	nner as st	ated.			
:	a Ho 24 h a Fui letely	Medical		Examiner: On the b					curred at the time, d						
	To th Mithir To th	Me	29b. Signature and title of certifier	•			29c. Licens		1	9d. Date signed	(Month,	Day, Year)			
ľ					1.	-07	-	D 4809	8	12/18	3 20	05			
	10		30. Name and address of person	who completed cau	ise of death (Iter	m 23a) (Type,	Print)				1	-			
	1.7		Vijay Kar					ghway -	Crisfield	, MD 21	817				
	Sta	ate	31. Date filed (Month, Day, Year)	32. 8	Registrar's Sign	ature		*							
	Registr	rar	DEC	2 2 2005	Parana.	A.	109Ks								

		1- State of Maryland State of Maryland		rtment of Heal			200	5 4	1325
		Decedent's Name (First, Middle, Last)		outo or Bot		2. Date of Deat			3. Time of Death
Physici		Eston McAvoy, Jr.				Decembe	Day	Year	6:30 AM
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca				ty of Death	
		Lions Manor Nursing Home		Cumbe			Α	11egar	ıy
Funeral		5. Sociat Security Number 6. Sex 7. Age ( <i>In yrs. la</i> 22.6 26 2010 1 2			Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthol	ace (State or Foreign
Director		226-26-3010 124 2 F 82 Usual Residence of Decedent	Yrs.			Oct. 4,	1923	Peter	sburg, WV
land			Town or Loc	cation				10	d. tnside City Limits
Many	to	WV Mineral	Burli:	acton					1 ☐ Yes 2 XNo
death with the Maryland me 23a or 28e-f show rmust be notified at	Director	10e. Street and Number	DULLI	10f. Zip Code		1	0g. Citizen of	What Count	iry?
th wit		Rt. 1, Box 224-B		26710			US	Α	
r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of Hispan Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto I	cify Yes or No- Rican, etc.)	14. Ra	ce - America	
36 s afte	<b>by</b> Fu	1 Never Married 2 Married 1 Xes 2 No If Yes, Give 3 Widowed 4 Xovorced 1 Yes, or o Dates:		***	ecify:		Spec	4	SA
5-003		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education	16a Deced	ent's Usual Occupation			16b. Kind of I		
115. In 72 and 12  plet	(Specify only highest grade completed)	(Give i	kind of work done during OO NOT use retired)	most of working	ng	TOD. Raing of t	203111633/1110	ustry	
Z 222	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Self	Employed 1	Mechani	c	Auto	motive	
/land 2: /land 2: // wild be filed v Mental Hygie syked other t	Bec	17. Father's Name (First, Middle, Last)		18. 1	Mother's Name	(First, Middle, M	Maiden Surna	me)	
Ment days	<sup>2</sup>	Eston McAvoy, Sr.				Ellen Re			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or iteme 23e or 28e-1 show any injury or other treumatic event, the Medical Estantinet must be notified at once.		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and N				•	Code)
e, N		Dianne Biser/ Daughter  20a. Method of Disposition 20b. Pla		1, Box 68-	1		WV 20c. Location		un State
Tor or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	netery, crem	natory or other place)	Dec. 200	20	Antioc		wii, State
MCAVDU, altimore, Mai mit. Pages 1 and 2 st partment of Health and portent: If item 27 is n youty or other treun		* 4 □ Donation 5 □ Other (Specify) Th  21. Signature of Fundral Service Licensee		Cemetery  Name and Address of F		-			
Bal Permi Depari Import		· Mun Friell	10	Rt. 2, Box	k 1-A		ton, W		710
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		1	1	r respiratory arre	est,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	1400	cardiac	Ling	cureti	M	-2	= Zeproin
/Medical Examiner		Due to (or as a conseque	nce of:		1				1 5
	Je.	Sequentially list conditions, b	- Atc ean	-	C	<u></u>			<u>-</u>
1 Insit	Examiner	Sequentially list conditions, if any, leading to him obtait cause. Enter Underlying Cause (Disease or injury that initiated events	,						
by A	Exa	resulting in death) Last C. Due to (or as a consequence)	nce of):						
18760, cate be executed physician and the burial-transit	dical	d.							
rtifica	Med	IF FEMALE:							
P.O. Box nat the death cert d by the attendin	Physiclan/Me	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal of	eath 3	Ectopic pregnancy			T.	ate of deliver	y Day Year
O. E. In the all the a	/sicl	1 Yes 2 No 9 Unknown 4 Pregnant at time of dea	th 5 🗆	Other (specify)			141	OHU!	Jay
ds, P.O. Box 6  iries that the death certific signed by the attending to the detached for use as		Part II. Other significant conditions contributing to death but not result	ing in the un	derlyind\caus\ given infl	Part I	23e. Did tob	acco use cor	tribute to the	cause of death?
Division of Vital Records, P.O. Box 6 or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	ed by	C.V.A, COPD, C.H.F	Re	nal fail	line	1 □ Ye	7	3 Proba	
aw requ	Completed					24a. Was ar		Were autop	sy findings available ipletion of cause of
The I	mo;					perforn		death?	No
Vital Rec sician: The law s certificate has E	Bec	25. Was case referred to medical examiner?			Place of Death	(Check only on	/ -		
of V hysic	2	1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ E	P/Outpatient		Nursing Hon	ne 5 🗆 Reside	nce 6 □Ot	her (Specify,	
r go eith	on:	1 Natural 5 ☐ Pending (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?		8d. Describe ho	w injury occu	rred	
Sic Isend Geath Itor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	- 4	M 1 Tes		8f. Location (Sti	root and Num	har or Russi	Pauta Mumbar
Div A after Direct Dire	Certification;	4 Homicide determined 28e. Place of Injury - At hon building, etc. (Specify)	e, iaiii, stie	et, factory, office		City or Town	, State)	oei oi nuiai	Adule Number,
Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate he	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination)	edge, death n and/or inv	occurred at the time, da estigation, in my opinion	ite and place, a	nd due to the ca	tuse(s) and mate and place	anner as sta	ited. the cause(s)
o the ithin 2 o the	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License num	nber	25	9d. Date sign	ed (Month. E	Pay, Year)
F 2 E 8		NI N Daniella		# D19	750	1	0000	loor	10 2005
		30. Name and address of person who completed cause of death (Item:	3a) (Type 1	Print)	130	4	ucur	NOW	17,0000
5		Vimala Ranjithan, MD 517 31. Date filed (Month, Day, Year) 32. Registrar's Signatu	oldt	- 1	iumbe	rland,	MD .	21502	3
Sta Registr		DFC 2 2 2005	B A	porte					

LAUREN M. MILLS 05-08577 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Amend/Unpend  1 - State Registrar	item#5,23a,2 State of Ma	7 <b>perM</b> aryland	<b>E.(851</b> , 17 Depa				ind Me			05	4132	6
		Registrar  1. Decedent's Name (First, Middle, La.	st)		Cei	rtificate	e or L	Jeath	ž.	2. Date of De		- Year-	3. Time of De	ath
Physicia /Medic			Lauren	Mari	e Mill					DECEMB	ER 19,		6:05A.	M
Examine		4a. Facility Name (If not institution, giv HOWARD COUNTY GEN		TAL		COL	UMBI	Location of	f Death			inty of Death		
Funeral Director		5. Social Security Number 6. S 220-73-7030	ex 7. Age □M 2ÅF	e (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days 1 0	If Under 2 Hours	Min.	B. Date of Bir (Month, Da Dec 9,	th ay, Year) 2005	Cou	place (State or Fo ntry) land	oreign
9 pu ≱	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City L	imits
death with the Maryland ma 23e or 28e-f ehow frauet be notified at	ğ	MD Howard		Col	umbia								1 [] Yes 2]	⊠ No
ith the M or 28a-f	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
23a c	alD	7555 Rain Flower	Way			210					U.S.A			
after dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	0- 14,	Race - Ameri Black, White		
036 urs aft	byF	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 if Yes, Give Year or Dates:	40		1 ☐ Yes 2	2X No	Specify:			Sp	ecify: Whi	te	
re, Maryland 21215-0036 s 1 end 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. If the marked other then "natural", or Items 23e or 28e-1 ehov other treumstic event, the Medical Examinar must be notified at	Completed by	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usua kind of wor	I Occupa	ation	of working		16b. Kind	of Business/Ir	ndustry	
212 18 18 17 18 18 18 18 18 18 18 18 18 18 18 18 18	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT us	e retired	)	or working	9				
nd 212- filed within 1 Hygiene. other then	S	0 17. Father's Name (First, Middle, Last			n/a			18. Mothe	r's Name	(First. Middle	n/a n, Maiden Sui	name)		
ylanc	o Be	Theodore R. Mills								ie Kov	-	,		
Aarylan 2 should be 1 and Mental 1 e marked of	ဥ	19a. Informant's Name/Relationship (			19b. Maili	ng Address	(Street a				er, City or To	wn, State, Zi	o Code)	
re, Marit and 2 Health a tam 27 le		Theodore R. Mills	/father	-,				wer Wa			ia, Ma			Ļ
0 00		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	Removal from State	20b. P	lace of Dispo emetery, crea	nsition (Nan matory or o	ne of ther plac		Da		20c. Locat	on - City or T	own, State	
timent tment tent: b		4 □Donation 5 □ Other (Special	y)	Iv	y Hill					3, 05	Laure	l, Mar	yland	
Baltimo		21. Signature of Funeral Secreta Lice	S98	M007	I		dson	Fune	ral H	lome, I			707 4200	`
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused									and 20	707-4389 Approximate	
Physician		Immediate Cause (Final											Interval Betwee Onset and Dea	ath
/Medical		disease or condition resulting in death)	a. Bronchopn  Due to (or as											
Examiner		Sequentially list conditions,	b											
ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):							- 1		
760, le be executed /sicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):									
760, te be ex	calE		d											
Box 687( leath certificate to attending physical for use as the to the total for the t		IF FEMALE:	-											
Box eath cert attending for use	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 🗌 Fetai	death 3	⊒Ectopic pr					23d	Date of deliver Month	ery Day Yea	ar
O. In the description of the des	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	4∏Pregnant a 9☐ Unknown	t time of de	eath 5L	Other (sp	юспу) <u> </u>							
Division of Vital Records, P.O. for Attending Physicien: The law requires that the district death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director.	Ď	Part II. Other significant conditions	contributing to death b	out not resi	ulting in the u	inderlying c	ause give	en in Part I.			tobacco use		the cause of deal	
Cord	eted												//	
Rec he taw has t	Completed										ormed?	prior to co	opsy findings ava empletion of caus	se of
on of Vital Reding Physicien: The In-	Be Co	25. Was case referred to medical						26. Place	of Death	(Check only	2□ No one)	1 🔼 Yes	2 No	
f Vi	To B	examiner? 1∭ Yes 2 □ No	Hospital:	ent 2 🗓	ER/Outpatie	nt 3 DC	Oth	00			idence 6	Other (Spec	fy)	
n Of ng Ph fter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time of Injury		28c. Injun Worl	k?		8d. Describe	how injury o	ccurred		
Sion tendin feeth. tor: Aft	catl	2 Accident investigation		44.6	40	M		Yes 2 □		Of Location	(Stract and A	umbor or Ru	ra <i>l R</i> oute Numbe	
Oivi or At efter d Direct	Certification:	4 Homicide determined		tc. (Specif	ome, tarm, st	reet, tactory	y, office		2		own, State)	umber or Au	ai Houle Number	,
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer deeth.  To the Funarel Director: Affer this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2X Medical Exa	nysician: To the best miner: On the basis of	of examina										
thin 2 the 1 mplet	Medical	29b. Signature and title of certifier	and manner st	ated.		290	c. Licens	e number			29d. Date s	igned (Month	. Day, Year)	
T. 3 T. 8		) Parché	Halla	av	ud			M.E.				BER 20,		
		30. Name and address of person who	. , , , , ,			, Print)								
		CAROC HAZ	LANNO			111	PEN	STRI	EET B	ALTIMO	RE MAI	RYLAND	21201	
Sta Registr		31. Date filed (Month, Day, Year)		rar's Signa		tack !	,							

			for State Registrar	000	Sta	ate of M		/ Dep		of H	ealth a	and M	lental Hy		e O	0.5		327
			1. Decedent's Name (F	irst, Middle,	Last)								2. Date of De	ath		<u> </u>	3. Tin	ne of Death
	Physicia /Medic		LAURA	FRA	NCES		MINNI	ECK.					DECEMBI	er 1	ĕ,	$2005^{\text{Year}}$	5:	10 P.M.
	Examin		4a. Facility Name (If no	t institution, (	give street	and number,	)		4b. City, T	own, or	Location o	of Death		40	. Cou	inty of Deat	h	
			FOREST HI	LL HEA	ALTH (	& REHA	B CENT	CER		FOI	REST	HILL				HA	RFOR	D
	Funeral		5. Social Security Numb		. Sex 1 □ M 2		ge (In yrs. las		If Under 1 Months	Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year	)	9. Birtl Co	nplace (St untry)	ate or Foreign
L	Director		222 <b>–</b> 10 <b>–</b> 2631		1 🗆 IVI 2		89	Yrs.								Penr		
	and **		Usual Residence of De 10a. State 10	b. County			10c. City,	Town or L	ocation								10d. Insid	de City Limits
	Maryl f sho	٥	Maryland	Harfor	fo.		Re	el Ai	r									Yes 2 No
	the 1	rect	10e. Street and Numbe		<u> </u>				10f. Zip 0	Code				10a. Ci	itizen	of What Co	untry?	
	3a or	Funeral Director	1413 N. Fo	untair	ı Gree	en Roa	d .				21	015				JSA	•	
	ma 2	era	11. Marital Status		12. W	as Decedent	Ever in U.S.	. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	p-		Race - Ame		ın,
9	after or ita	표	1 Never Married	2 Marrie	d 1 [	med Forces □Yes 2			1 Yes, specif			1, Pu <i>er</i> to	Hican, etc.)			Black, White	a, etc.	
03	rai', c	l by	3 XWidowed 4 □	Divorced		Yes, Give ear or Dates:			1 U 1 0 S 21	£3 NO	Specify:				Spe	ecify:	White	e
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itama 23a or 28a-f show na Madical Examinar must be multiped at	Completed	15 (Specify o	Decedent's only highest	Education grade com	pleted)		(Give	dent's Usual kind of work	k done a	luring most	t of work	ing	16b. h	(ind o	f Business/	Industry	
121	han han	ם	Elementary/Seconda			ollege (1-4or	5+)	life.	DO NOT use	e retired,	)				_	_		
	filed v Hygie othar t		17. Father's Name (Firs	et Middle I:	ct)			Ins	pector	•	18 Mothe	r'e Name	e (First, Middle		P	Gover	nmen	t
anc	ould be f Mental h arkad of atic ava	Be	· · · · ·	erov	Reyn	014c					Mar		arjorie		ear			
Maryland	2 should be filed within and Mental Hygiene. Is markad othar than aumatic avant, the M	ို	19a. Informant's Name	2				19h Maili	na Address /	(Street a			ar JOLIC				in Code)	
Ma	and 2 sealth an m 27 is har trau		Pat E. Pe										Baltir	-				
ē,	- T m =		20a. Method of Disposi		•			ce of Disp	osition (Name matory or oth	e of	a) 1		Date	20c. L	.ocatic	on - City or	Town, Sta	te
Baltimore,	Pages nent of I int: if its ury or o		1X Burial 2 □ C			al from State	'	_			1	2=20	-05	Pol.	7\ -	ir, Ma	neral ar	Бл
alti:	parmit. Pag Department Important: I any injury o		21. Signatur# pf Funet	-		1	Suru		Cemete Kanang				me, P.A		AJ	Pic	тута	na
ä	parm Depa impo any is		Steale	1 1	[ [[lec	cels		1					d, Abir		n,	Maryl	and	21009
			23a. Part1. Enter the c shock, or heart fa	disease, or or	omplication	s that cause	d the death.										Approx	
	Physician		Immediate Cause (Fin disease or condition		.,	Praa	10551	110	Dem	0 n	tiv.	- 02	shably	X	~	heime	Onset a	and Death
	/Medical		resulting in death)	- 1	7 a	Due to (or as	s a conseque	ence of):	DOM	<i></i>	12	1	O Selving	/)	<u> </u>	L	-	years
	Examiner	١. ا	Sequentially list condit	ions.	b											17/4		7000
	sit ad	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyii Cause (Disease or inju-	diate ng		Due to (or as	s a conseque	ence of):										
	and and I-tran	хаш	that initiated events resulting in death) Last		c	Due to (or as	s a conseque	ence of):										
760,	eath certificate be exacuted attending physician and for use as the burial-transit	calE			0	000 10 (0. 0.	- a 551155 que											
687	# × 6				d													
Вох	death certifica e attending ph id for use as th	N/M	IF FEMALE: 23b. Was decedent pre	egnant			e of pregnanc								23d.	Date of deli	very	
Ď.	0 0	icla	in the past 12 mo 1 ☐ Yes 2 ☐ N	nths?	41	Pregnant a	2 🗌 Fetal d at time of dea		⊒Ectopic pre ⊒ Other (s <i>pe</i>							Month	Day	Year
P.0	The law requires that the deatt ate has been signed by the atte bage 2 should be detached for	by Physiclan/Med	9 🗆 Unknown		91	Unknown												
	es tha igned be de	by F	Part II. Other significa	nt condition	s contribut	ing to death	but not result	ting in the u	inderlying car	use give	en in Part I.					contribute to		
Records,	w requir been si should I	ted	- Chr	-ama		Trial	- h	ndy	11101				1	Yes 2	No	3 Pro	obably 4	□Unknown
ecc	e law r has be je 2 sh	ple	- Car	dio-r	NUM	PXh	<b>/</b>						24a. Was	DSV	24	b. Were au	topsy findi	ings available of cause of
E E		Completed			/ .	) /								ormed?	5	death?		
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred examiner?	to medical							-	of Death	(Check only	one)				
of	di Si	ို	1 Yes 2 No		Hospit	1 🔲 Inpati	ient 2 🗆 El			-	4 Privu		me 5 ☐ Resi				city)	
n C	ng After	on		5 Pending		a. Date of Inj (Month, D	ay Year)	28b. Time o Injury	M 28	ic. Injury Work	rat ⟨? Yes 2 🗀 !		28d. Describe	now inju	ry occ	currea		
Division	i or Attending after death. Director: After in by the fune	icat	2 ☐ Accident 3 ☐ Suicide	investiga 5 □ Could no	t be	e Place of In	njury - At hom	ne farm st	_		165 2	140	28f. Location (	Street a	nd Nı	ımber or Ru	ıral Route	Number.
Div	after Dire	Certification;	4  Homicide	determin	ed	building, e	tc. (Specily)	-0, 14,777, 31	root, ractory,	ottioo			City or To					
	spita nours naral / fillec	alc	29a. Certifier 1	ertifying	Physician	: To the best	t of my knowl	ledge, dea	th occurred a	t the tim	e, date an	d place,	and due to the	cause(s	and	manner as	stated.	
	To tha Hospital or Attend within 24 hours after death To tha Funaral Director: completely filled in by the	Medical	(Check only 2[ one)	_ Medical Ex	kaminer: C	on the basis on the manner s	of examination tated.	on and/or in	ivestigation, i	in my op	oinion, dea	th occurr	ed at the time,	date an	d plac	ce, and due	to the cau	ise(s)
	To the To the comp	Σ	29b. Signature and title	of certifier	100	1//			29c.	License	number			29d. Da	ıte sig	ned (Month	, Day, Yea	ar)
•	2		PCYN	am	111	VY	ND			DI	958	3		No	CR	mbe	r1	7-2005
			30. Name and address			//							0.5.0.5					,
7			DR. MANUE	EL LAZ	ATIN	1	LAW ST	CREET			DEEN,	MD.	21001	L				
	Sta Registi			EC 2 2	2005	JZ. FINGISI	trar's Signatu	K A	Cart	*								

		•	For State Registrar	State of Ma		partment of Hea e <i>rtificate of De</i>		Hygiene Reg. No.	105	41328
r	Dhysici	217	1. Decedent's Name (First, Mid-				2. Date Mont	h Day	Year	3. Time of Death
	Physici /Medic		Alta Mary Mroz					-19-2005		1:10p M
	Examin	er	4a. Facility Name (If not instituti	_		4b. City, Town, or Loc			County of Deat	
	Funeral		11 Oak Lane SW 5. Social Security Number		e (In yrs. last birthda		Jnder 24 Hrs. 8. Date	of Birth	nne Aru	hplace (State or Foreign untry)
۴,	Director		219-18-4376	1 □ M 2 ဩ F	36 Yrs.	Months Days He	ours Min. (Mont	h, Day, Year) L4-1919		D
	pu k		Usual Residence of Decedent  10a, State 10b, Coun	h	10c. City, Town or	Location				10d. Inside City Limits
	faryla r shor	ō		Arundel	Glen Bur					1 ☐ Yes 2 🛣 No
	the A	Director	10e. Street and Number	Alundel	Gren but	10f. Zip Code	-	10g. Citize	en of What Co	untry?
	h with		ll Oak Lane SW	J		21061		U.S.	Α.	
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes		4. Race - Ame Black, White	
ဓ	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23e or 28e-f show event, the Medical Exotr her death by molified at	by Fu	1 Never Married 2 Ma	arried 1 ☐ Yes 2 🔯 I If Yes, Give	No		овсіту:		Specify: Whi	•
Maryland 21215-0036	hours tural'		3 ☑ Widowed 4 ☐ Divorce	ent's Education	16a Dec	edent's Usual Occupation			d of Business/	
Ç	n na n na	Completed	(Specify only high	nest grade completed)	(Giv	re kind of work done during DO NOT use retired)	g most of working	Tob. Kill	1 01 003111933/1	industry
212	d with	шo	Elementary/Secondary (0-12)	) College (1-4or 5		memaker		0	wn Hom	e
2	m - 0 5	ВеС	17. Father's Name (First, Middle	e, Last)		18.	Mother's Name (First, M	iddle, Maiden S	lumame)	
Уa	should be nd Menta marked umatic ev	٦	Robert White H				Innie Helen			
Mar	" h ]		19a. Informant's Name/Relation			iling Address (Street and f				(ip Code)
e,	1 and 2 Health a		Mrs. Sherrie C	hampagne/Daug	20b. Place of Disa	position (Name of	Date		DIU/5 ation - City or	Town, State
ğ			•	n 3 □Removal from State	cemetery, cr	ematory or other place) ill Cemetery	12_22.20		•	
Baltimore,	permit. Page Department Important: if eny injury or once.	1	21. Signatur of Funeral Ser	NOTE OF THE PARTY		22. Name and Address of				
ñ	Ped Lang		Lonna	Jahas /11	013/04 1		SW; Glen Bu			
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caused ist only one cause on each li	d the death. Do not e	nter the mode of dying, su	ich as cardiac or respirat	ory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Coror	VARY A	RIFRY D	SEASE			Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):					
Н		er	S uentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):					
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>						
ó	en an	Exa	resulting in death) Last	Due to (or as	a consequence of):					
68760,	ficate be executed g physicien and as the burial-transit	edical		d						
_	75 m	Med	IF FEMALE:	One Marine suterman					1	
Box	eath certifi attending   for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pregnancy		23	3d. Date of deli Month	ivery Day Year
o	the de py the datached	ıysic	1  Yes 2  No 9  Unkn <i>o</i> wn	9□ Unknown	tune or death 3	Cities (specify)	-			
ر. ص	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use		Part II. Other significant condi	itions contributing to death b	ut not resulting in the	underlying cause given in	Part I. 23e.	Did tobacco use	e contribute to	the cause of death?
ğ	w require been sig should b	ed b	CONGEST	NE HEA	RT FA	ILURE		1 ☐ Yes 2 🔀	No 3□Pr	obably 4 Unknown
000	law re as be 2 sho	Completed by					24a.	Was an autopsy	24b. Were au	topsy findings available
Vital Records,		Com					10	performed? /es 2☑No	death?	2 No
Vita	Attending Physiclan: The rideath. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medic examiner?	Hospital:		0.4	Place of Death (Check	7	-	10.00
	Phys	: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpatie	ent 2 ER/Outpati		Nursing Home 5	ribe how injury		cify)
Division of	ding th. th. After funer	tion	1 ☑Natural 5 ☐ Pend		y Year) Injury			noo now injury	00041190	
<u>                                      </u>	or Attendate death Director:	ifica	3 ☐ Suicide 6 ☐ Coul	ld not be 28e. Place of Inj	ury - At home, farm,	street, factory, office			Number or Ru	ral Route Number,
	tel or At s after o el Direct ed in by	Certification:	4   Homicide	building, et	с. (Зреспу)		Chy	or Town, State)		
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical	(Check only 2   Medic	ying Physician: To the best ai Examiner: On the basis o	f examination and/or	ath occurred at the time, di investigation, in my opinion	ate and place, and due to n, death occurred at the	the cause(s) a	nd manner as place, and due	stated. to the cause(s)
	thin 2 the I	Med	29b. Signature and title of certif	and manner sta	ated	29c. License nur			signed (Month	` '
	£ <u>₹ ₹ 8</u>		N A B	una	-					**
	χ.	1 9	30. Name and address of pe so	on who completed cause of c	feath (Item 23a) (Type	e, Print) 1 1 C LA A	VEANN	11/20	te MBI	-R 20 200
	10			NINGTON	AVEN	JUE BI	TIMOR	E M	D 2	20, 200 226
	Sta		31. Date filed (Month, Day, Yea	406	ar's Signature	Cocally D	,	)	, -	
	Registr	ar	DEC 2	2-2005	21 85° FE	The state of the s				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 December 3:45 AMM 10, Joseph E. Maxwell /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 8274 Bullneck Road Dunda1k If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ₹ M 2 □ F 78 Director 219-22-4052 27, 1927 Maryland Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Baltimore Dunda1k 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examinar mercent and items 13 and 18. 8274 Bullneck Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 steel worker Armco Steel Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Vernon Maxwell Marie Stoney ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Regina Maxwell/spouse 8274 Bullneck Road Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Lervice Licensee Romald S. Wade State Anatomy Board 655 W. Baltimore Street erren MILL Baltimore, MD 2120; Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) Ten d **Physician** Commany seaso /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physician Be Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be hear arlows 1 TYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Kena INSUM director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after deatl Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 15/05 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 ΛQ 160 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink Ensure All Conie

				State of Maryland / Department of Health and Mental Hygiene 1 1 2 2 0	
				1- For State of Waryland / Department of Health and Wernar Aygione 0 5 4 3 3 0	
	×.	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day ( Seat DE 2004)	
		/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	٣
	100	Funeral		5, Social Security Number 6. Sex / 7. Age (In yrs. lagt birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore	
	73	Director		123-05-5449 1 M 2 VF 84 Yrs. Months Days Hours Min. (Month, Day, Year) Gountary)	
		ryland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
		the Ma 28a-f e	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Ñο
		23a or	al DI	305 Princeton Lane 21014 USA	
an	G	hours after death with the Maryland turst', or iteme 23a or 28a-f ehow al Examiner invest by molling at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 New or Married 2 Married 2 Married 1 Yes 2 No	
Ŏ	003	hours a turet', c	ed by	3	
53	215	ithin 72 ie.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
0	d 21	filed w Hygien other th		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturat", or iteme 23s or 28s-f ehow any injury or other traumatic event. The Medical Examiner must be notified an once.	To Be	melvin Gay Faris Virginia Alice Taylor	
3	Mar	nd 2 shullth and 27 ie m		19a. Informant's Name/Relationship (Tybe, Print)  19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)	
$\frac{2}{c}$	ore,	ges 1 av t of Hea If item or othe		20a. Method of Disposition  1 Definition 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20b. Location - City or Town, State	
30/11/c	Baltimore,	nit. Pagartmeni ortent: injury		4 Donation 5 Other (Specify) Parkupan Completed: 2005	_
4	B	Depa Depa Impo any ir		Mubuly G. Kayrothy 8800 Harford rd. Parkville, mp 21234	
4		Dhysisian		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Immediate Cause (Fina)  Approximate Interval Between Onset and Death	
		Physician /Medical Examiner		disease or condition resulting in death)  a	
		LXdiffille	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)  Due to (or as a consequence of):	
i	V	be executed iician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
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#44	89 x	w requires that the death certificate be execu been signed by the attending physician and should be detached for use as the buriat-tra	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
#	Box	death ne atten	Physician/Med	and the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  1 ☐ Ves 2 ☑ No  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
(0	P.O.	requires that the death een signed by the atter hould be detached for u		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
in	ords	equires en sign ould be	ted by	1 Yes 2 No 3 Probably 4 Inknow	ΝN
auline	Vital Records,	The law ruite has be	Completed	24a. Was an autopsy performed? 24b. Were autopsy findings availat prior to completion of cause of death?	ole of
0	ital	ien: Th rtificate ctor, pa	Be Co	25. Was case referred to medical examiner?  26. Place of Death   Check only one	-
=	of V	Physic rthis ce ral direc	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)	
weel	sion	ending sath. or: After he fune	atlon	1  Natural 5  Pending (Month, Day Year) Injury Work? 2  Accident investigation M 1  Yes 2  No	
E	Division	lor Att	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
<b>-</b>		To he Hospitel or Attending Physicien: The law within 24 hours after death. To he Funerel Director: After this certificate has i completely filled in by the funeral director, page 2		29a. Certifier  Conex only  The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
		ro he h	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
		F > F 0		D 0062704 12.21.2005	
		10		30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)  Kar I K J De5 : 0 Upper S D Dr 3 A'V	
		Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	DH	MH 17 Rev 1/2	- 2	DEC 2 2 2005 Beach & Specific	
				ORIĞINAL	

			For State	State of Maryland / De	partment of Health an ertificate of Death		2000 41331
			Ragistrar  1. Decedent's Name (First, Middle, L.		erimoate of Death	Reg.	3. Time of Death
	Physic /Medi		Louise Odi	ell Kiley		DECEMBER	22 2005 430 AM
7	Examir	ner	4a. Facility Name (If not institution, gi SINAL HOSPITAL		4b. City, Town, or Location of D BALTI MORE		4c. County of Death
I	Funeral Director			Sex 7. Age (In yrs. last birthde 1 M 2 F Yrs.	Months Days Hours N	Hrs. 8. Date of Birth Min. Month, Day, Y.	9. Birthplace (State or Foreign Country)
	ryland how		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	the Mar 28a-f s	ector	10e. Street and Number	Balt	imore		1 Nes 2 No
	ours after death with the Maryland rel', or Items 23a or 28a-f show Examerat must be recitied at	Funeral Director	3603 Yarkvieu	Apt. B	2/207	Tog.	Citizen of What Country?
	ier dea Items	uner	11. Marital Status	12. Was Decedent Ever in U.S. 1: Armed Forces?	Was Decedent of Hispanic Origin?     If Yes, specify Cuban, Mexican, Proceedings of the Company of the Com	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	ours aft rel', or Exam	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: Black
1 17	in 72 hours "naturel", ledical Exe	oletec	15. Decedent's E (Specify only highest gi	rade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of a. DONOT use retired)	working 16	b. Kind of Business/Industry
212	filed within 72 hours after Hygiene. ther than "naturel", or Ite ont, I'm Medical Examera	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurse	+	ealth Care
Maryland 2121	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle Las	lo	18. Mother's	Name (First Middle, Mai	den gumame)
Mary	s 1 and 2 should be Health and Mental Item 27 is marked o other traumatic eve	-	formant's Name/Relationship	(Type, Prifit) 19b. Ma	ailing Address (Street an Mimber of	Hural R Juli Number, C	
	of Health of Health item 27		20a. Method of Disposition		thrist-tord toposition (Name of	L. T. Cosvil	c. Location - City or Town, State
Saltimore,	Pages ment of ant: If it ury or c		1 ABurial 2 Cremation 3 C	Removal from State		28/05 (	Davings Mills, MD
Balt	permit. Pages Department of Important: If ii any injury or o		21. Signature of Fundra Service Lice	Greene 8	22. Tope and Address of Placility	Randall	staun, MD 21133
ı			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	nplications that caused the death. Do not of one cause on each line.		diac or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	ry Arrest		
	Examiner		Sequentially list conditions,	SEPSIS			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate eause. Enter the onlying Cause (Disease or injury that initiated events	PNEU MONI A			
8760,	cate be executed physician and the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequence of):			
687	cate phys	edlcai		_ d			
Вох	eath certifi attending for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	t the de by the a tached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 5 9□Unknown	5 Other (specify)		Works Buy 1842
Division of Vital Records, P	es tha igned be de	ed by P	Part II. Other significant conditions FAILURE TO THE	contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
eco	e law requir has been si le 2 should	Completed	URINARY TRAC	T INFECTION		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B			OF Mos and referred to an elect			performed	death?
ΓŞ	Physician: 1 this certificat ral director, pr	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Yo	Hospital: 1 ★Inpatient 2 □ ER/Outpati	Other	Death (Check only one) g Home 5 \( \square\) Residence	a 6 ∏Other (Specify)
o uc	ding Ph h. After th funeral	lon;	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how in	
visio	Attender deatlest by the	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Injury - At home, farm,		28f. Location (Street	t and Number or Rural Route Number,
٥	ospitel or A hours after uneral Dired ly filled in by			building, etc. (Specify)		City or Town, Si	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  1☑ Certifying P.  2☐ Madical Exa	hysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death or	ace, and due to the cause ccurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the vithin roung	Ā	29b. Signature and title of certifie		29c. License number		Date signed (Month, Day, Year)
n	4		Mund	completed cause of death (Item 23a) (Typ	e, Print)	12	1000
1	- 12		AMAN SIBAL, MD	2401 W. BELVEDER	E AVE, BALTIMOR	E 21215	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 200	32. Registrar's Signature	de		

AEM 05-08214 Willi

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lla	m kawis	3	For State		epartment of Health and N Certificate of Death	6	2000 41332	
			Registrar  1. Decedent's Name (First, Middle, Las		A Death	Reg. i	No.  3. Time of Death	
	Physic		11/:11	iAM BOUD	Raush 5		Day 2005 6:20 P	
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		University Hosp  5. Social Security Number  6. S  217-86-3265  1  Usual Residence of Decedent	7. Age (In yrs. last birti	Raltimore City If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea APRILLE)	n/a  9. Birthplace (State or Fore) Country) MD	ign
	nylanc how		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limit	
	Be-1-	cto	MD. P/	BAC	TI MORE		1 Pes 2 N	10
	vith th	Dire	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?	
	e 23e	- a	2000 S. AR	LINGTON ST	N/A	1 1	0.5./4	
215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important; if Item 23a or 28e-f show important; if Item 27 is marked other then "natural", or Items 23a or 28e-f show any Injury or other traumatic event, If a Modical Evantra minet be notified at 2008.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 PNo Specify:	DECTLY YES OF NO- D Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WAITE	
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	. Kind of Business/Industry	
2	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	/	~	
121	tiled w Hygier ther ti		17. Father's Name (First, Middle, Last)		MECH.	(First Middle Maid	-ACIORY	
Maryland	Mental Harked of	Be		NKNOWN	18. Mother's Nam	ne (First, Middle, Maid	en Sumame) V	
Z	2 should and Men Is marke sumatic	ပ္	19a. Informant's Name/Relationship (1		Mailing Address (Street and Number or Ru	ral Bouta Number, Cit	V or Town State Zin Code)	
S	and 2 sealth ar		CollEN BUOK	HOLDER 12	823 SAND DOLLA	W 11)AV	BAJO . MD. 212	22
<b>e</b>	of Health of Health of Health of Hem 27 I		20a. Method of Disposition	comoton	Disposition (Name of	Date 20c.	Location - City or Town, State	-
Ę	Pages nent of int; If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	crematory or other place)  DEC	005 B	21TO MD.	
Baltimore,	permit. Pag Department Importent; I eny Injury o		21. Signature of Funeral Service Licen	DUL	22. Name and Address of Facility	879 11.17	2504 5	_
m	Depar Impo		Johnnes.	Sporde 1.	SKARDA F.H.	BALTON	MD-21224	
	Physician /Medical		23a. Part1. Enter the disease or com, shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of	tot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	
	Examiner		f	L	1).			
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90,	oe exe		resulting in death) Last	Due to (or as a consequence o	f):			
09/89	cate be ey physician i the buria	dical		d				_
Box 6	uires that the death certific signed by the attending f d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death	3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year	
P.O.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	y Ph	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?	
Records,	quires n sign	d by				1 🗆 Yes	2 No 3 Probably 4 Unknow	vn
00	s been si	Completed				24a. Was an	24b. Were autopsy findings availab	ole
Re	The Iste ha	E				autopsy performed?	prior to completion of cause of death?	í
of Vital	ian: 'rtitica	0	25. Was case referred to medical		26. Place of Deal	1 12 Yes 2 □ N th (Check only one)	No 1⊠Yes 2□ No	-
<b>†</b> \	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other	ome 5 Residence	6 ☐ Other (Specify)	
	ng Pt fter th neral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28b. Ti		28d. Describe how in		
Sio	Attending in death.	catic	2 ☐ Accident investigation	12-5-05 18:	05 M 1 Yes 2 Ko	Unknow	OO.	
Division	or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 A Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, office	28f. Location (Street City of Town, Sta	and Number or Rural Route Number,	
	oltal o			behin	id toilet	BIR	nere The Direction	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, hiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)	
	o the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	Date signed (Month, Day, Year)	
	⊢ s ⊢ ŏ		Matu aron	uch follow is	OCME		ecember 6, 2005	
	1		30. Name and address of person who a	0		, D	<u> </u>	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Regist		DEC 2 2 2	005	Sperte			_
DH	MH 17 Rev 1/2	UU1		4				

ORIGINAL

State of Maryland / Department of Health and Mental Hygienen 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Frances Louise Ryan December 17, 2005 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 14716 Shiloh Court Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F Director Yrs 229-38-8558 70 May 27, 1935 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at Director 1 Types 2 □ No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Itema 23a 14716 Shiloh Court 20708 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 te marked other than "natural", or Ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Bartender Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Ryan Buelah Allison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Dawn Lynn Kilby/Daughter 14716 Shiloh Court, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages Department of Important: If It any Injury or o 1 ☐ Burial 2XX remation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 12/21/2005 Odenton, 22. Name and Address of Facility Oonaldson Funeral Home, 21/Signature of Funeral Service Licenses 313 Talbott Avenue, Laurel, MD emu ( 23a. Part1. Enjer the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Carcinoma of Head and Neck Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2₺ No Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direc 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical vomolately (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Many D23743 December 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin D. Weltz, 7525 Greenbelt Center Drive, Greenbelt, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				artment of Health and Menta	al Hygiene 05	41334
			Decedent's Name (First, Middle, Last)		e of Death	3. Time of Death
Н	Physici /Medic		Maria Noemi Munoz Rudolph	Dec	ember 16, 2005	5:45 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ith
			1147 Court of Fiddlers Green	Bel Air	Harfor	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min. (Mo	onth, Day, Year)	thplace (State or Foreign ountry) hile
	Director		360-86-9684 44 III.	Sep	t. 12, 1961 C	1111C
	yland		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	e Mar	ctor	Maryland Harford Bel Air			1 ☐ Yes 2 X No
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
	s 23a	ral	1147 Court of Fiddlers Green	21014	Chile	
	itam itam	Funeral Director	11. Marital Status  1 Never Married	Vas Decedent of Hispanic Origin? (Specify Yef Yes, specify Cuban, Mexican, Puerto Rican,	es or No- etc.) 14. Race - Am Black, Whi	
38	urs af	by F	If Yes, Give  3 Widowed 4 Divorced Year or Dates:	☐ Yes 2 No Specify:	Specify:	White
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Maryland	hould d Mei mark matic	ř	Augusto Emiliano Munoz Bravo  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	g Address (Street and Number or Rural Route	-	
	lith and 2 s			Court of Fiddlers Gr		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinational be notified at once.		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Date natory or other place)	20c. Location - City of	Town, State
Ë	Page nent o int: If		1  Surial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Darlingto		Darlington	Maryland
ati	permit. Departri Imports any inju				mas Funeral Ho	
<u>-</u>	907 = 20			317 Cokesbury Road, A		Land 21009
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		ratory arrest,	Approximate Interval Between Onset and Death
	Physician		resulting in death)	CER		Onest and obtain
r	/Medical Examiner		Due to (or as a consequence of):			
	V.	e	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury)  Due to (or as a consequence of):			-
	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.			
o,	e exectan ar	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	Physiclan/Medical	d			
9	leath certific attending p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		201 2 11 11	
Вох	atten for us	clan	in the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date of de Month	Day Year
o.		ysic	1   Yes 2 No 9   Unknown	Total (speeding)		
S, P	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23	e. Did tobacco use contribute t	o the cause of death?
rds	w require been sig should b	ed b			1 ☐ Yes 2 ☐ No 3 ☐ P	robably 4 Unknown
eco	e law requ has been ye 2 shouk	plet		24	a. Was an autopsy 24b. Were a	utopsy findings available completion of cause of
Vital Record	Th ate pag	Completed		1	performed? death?	s 2 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec		
of	dis y	<u>۲</u>	1 ☐ Yes 2 No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of	TORREST TORRES	Residence 6 Other (Special Control of the Residence of Control of the Residence of	ecify)
on	ding h. After fune	tlon	Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No	Socials now injury occurred	
Division	I or Attanding Ph after death. Director: After th I in by the funeral	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, str.	eet, factory, office 28f. Loc	cation (Street and Number or F	ural Route Number,
Ö	s after s after al Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	Cit	y or Town, State)	
	Hospital or 24 hours afte Funaral Dir tely filled in I	edical	29a. Certifier (Check only (Ch	o occurred at the time, date and place, and due	to the cause(s) and manner a	s stated.
	To the Hospitel or Attentwithin 24 hours after death To the Funaral Director: completely filled in by the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
ì	D ≥ 1 8	Ī	Will Million	TVW63159	12/19/2	105
ļ	7		30. Name and addess of person who completed cause of death (Item 23a) (Type,	Print)	1-1110	<u></u>
_	U		AKIL MERCHANT, MD 401 N.B	ROADNAY, BALTI	MURE MD	2123
	Sta		31. Date filed (Month, Day, Year) 32. P gistrar's Signature	South !		
	Registi	ar	DEC 2 2 2005			

05-08537 RKD

			For State Registrar	State of Marylar	-	rtment of H			ene g. No. 0 0	5 41335
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	/Medic			C. Scheele				DECEMBER	17, 20	005 6:00P. M
	Examin	er	4a. Facility Name (If not institution, give st.			4b. City, Town, or	Location of Death		4c. County of	
			NORTHWEST HOSPITAL  5. Social Security Number 6. Sex	CENTER 7. Age (In yrs.	last hirthdayl	RANDALI If Under 1 Year	STOWN If Under 24 Hrs.	R Date of Righ	BALTIMO	ORE  9. Birthplace (State or Foreign
	Funeral Director			_	Yrs.	Months Days	Hours Min.	8. Date of Birth Month Day, NOV 12,	1954	Mary Land
	yland Iow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Man Man	Ď	Maryland Baltim	ore		Cato	nsville			1 ☐ Yes 2 ZNo
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?
	23a	<u>a</u>	6107 Burnt Oak Roa	ıd			228		US	SA
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow mith fighty or other traumatic avent, Ira Marical Exartinatic and indifficial at DDCs.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Noivorced	2. Was Decedent Ever in U Armed Forces? 1		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	ispanic Origin? (Si in, Mexican, Puerti Specify:	pecify Yes or No- perican, etc.)		r-American Indian, c, White, etc. White
5-0	natur natur	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	ent's Usual Occupa	ation during most of wor	kina 1	6b. Kind of Bus	siness/Industry
2	iffin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	)		ainting	
2	led w tygier her ti	õ	17. Father's Name (First, Middle, Last)		Pai	nter	10 Matheda Na	ne (First, Middle, M.		ruction
anc	ntal H ed ot	Be	William Carson So	shool o				7 Fitzger		9)
Ž	should be ind Mental I	ဥ	19a. Informant's Name/Relationship (Type		10h Mailin	n Address (Street		ral Route Number,		State Zin Code)
Ma	and 2 selth an n 27 is in trau		Diane M. Scheele/Si		100			atonsville		
	Heel tem to		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of	i			City or Town, State
آ ا	Pages nent of I int: if its iry or o		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State Ne	w Cathe	edral Cem	etery 12	/22/05	Balti	more, MD
Baltimore,	permit. P Depertme importar any injur		21. Signature Funeral Service bicenses  Religion d.A. Grege  Edward A. Grege	lil	22			cNabb Fur Road Cato		ome, P.A. e, MD 21228
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	th. Do not ente					Approximate Interval Between
8760,	Physician bubble executed bubble buysician and bubble physician and the principle butble butb	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that intitated events resulting in death) Last  d.	Due to (or as a consec	quence of):					
P.O. Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be deteched for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
	quires that n signed b uld be dete	Ď	Part II. Other significant conditions cont	ributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba		bute to the cause of death?  3 Probably 4 Unknown
Il Records,	(G) CL	Completed						24a. Was an autopsy perform	ed? de	Vere autopsy findings available for to completion of cause of sath?
Vital	Physician: Tribis certificateral director, p	Be	25. Was case referred to medical examiner?			Tax		th Check only one	,	
of	Physic this o	မ	X 162 5 140		ER/Outpatien		4 U Nursing n	ome 5 Residen		
Ň	ding f	o	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		fell from		
isic	Attanding r death. actor: After by the fune	cat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Dec 17, 2005			Yes 2 □No			r or Rural Route Number,
Division	or A after Dirac in by	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	et, lactory, omce		City or Town,	State)	Wastlaun MD
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kni er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my of	ne, date and place pinion, death occu	, and due to the cas	use(s) and man	iner as stated.
	o the	Med	29b. Signature and title of certifier	- Stated.		29c. License	e number	29	d. Date signed	(Month, Day, Year)
	<b>- s -</b> ō		1 Jan LM	cel ner	)	0.0	.M.E.	חת	C.E.W.E.D	19 2005
7	2		30. Name and address of person who con	npleted use of death (Ite	m 23a) (Tvne		·11 · E ·	DE	CEMBEK	18,2005
	5	1 4	Tasha Z Greense	1 0 00	, (1) po,	•	STREET	BALTIMORE	MARYT.A	ND 21201
	Sta	ite	31. Date filed (Month, Day, Year)		ature					
	Registi		DEC 2 2 200	32. Pegistrar's Sign	A. Ago	sur!				

			1 - For State Registrar	State of Ma	aryland				ealth a Death	nd Me		giene Reg. No.	005	413	36
3 - 3 - 6	Physic	ian	Decedent's Name (First, Middle, Last)							1	2. Date of Dea Month	ıth	Year	3. Time of	
	/Medi	cal	Keenan Spruill  4a. Facility Name (If not institution, give s	stroat and number)			4h Cin	Tour		Death	DEC	Pay	2005	750	A M
	Exami	ner	il as in the all all a	and Medical	Cont	20	46. City	S	Location of	Death		4c. (	N/A	٦	
	Funeral	3.4	5. Social Security Number 6. Sex	7. Ag	e (In yrs. la	ast birthday)		r 1 Year	If Under 2		B. Date of Birtl	1		nplace (State o	or Foreign
18/2	Director		212 13 3213	M 2□F	33	Yrs.	Months	Days	Hours	Min.	(Month, Day 04-17 <b>-1</b> 9	7, Year)	Mary		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Ci	ity Limite
	Maryl-1 sho	ō	MD NA			Ba1	timore	<u>ء</u>						1XXYes	•
	r 28a	Director	10e. Street and Number					p Code				10g. Citiz	en of What Cou	intry?	
	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show redical Examinar must be notified at		6540 Falkirk Road					212	39				USA		
	tems	Funerai		12. Was Decedent I Armed Forces?	Ever in U.S	S. 13. \	Was Dece f Yes, spe	dent of Hi	spanic Origi n, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	1	4. Race - Amer Black, White		
36	rs afte	by Fe	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>XX</b> If Yes, Give Year or Dates:	No		1 🗆 Yes	2 X No	Specify:				Spanifu:		
21215-0036	2 hour	edk	15. Decedent's Educ	ation		16a. Deced	dent's Usu	al Occupa	ition			16b Kin	BLa d of Business/l	ack	
215	_	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	(+)	(Give	kind of wo	ork done d ise retired,	uring most of	of working	,			industry.	
21	T) 'E	Completed	12	4			Mana	ager				Dat	a Manager	ment Co.	
pu	o ta o y	Be	17. Father's Name (First, Middle, Last)					ŀ			First, Middle,	Maiden S	Sumame)		
Maryland	s t and 2 should by the alth and Mentation 27 is marked other traumatic expenses.	2	Lonnie C. Spruill Jr.  19a. Informant's Name/Relationship (Type	na (Reint)		105 11 31		(2)			pruill				
Ma	nd 2 sho lith and 27 is m		Lonnie C. Spruill Jr.								$1\mathrm{s}$ , MD $2$		Town, State, Zi	p Code)	
Baltimore,	f Heal		20a. Method of Disposition		20b. Pla	ace of Dispo metery, crem				Dat			ation - City or T	own, State	
E O			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State		metery, cren o Crema		otner place		-21 <b>-</b> 0!	5	Cato	nsville,	MD	
alti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service License	99	LECEL		_	nd Addres	s of Facility	21 0.		Galo	noville,	TID	
<u>m</u>	88 5 8		Manne			Wy	lie Fu	meral	Home P	.A. 63	38 N. Gi	lmor	St. Bálti	more, MI	21217
X	Physician /Medical Examiner	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any leading to account on the cause. Enter Underlying Cause (Disease or injury)	Sepsion	a conseque	,								Interval Betwonset and D	Death
х 68760,	leath certificate be executed attending physician and for use as the burial-transit	dical	that initiated events resulting in death) Last d.	Due to (or as a											
P.O. Box	t the d by the ached	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3 🗆	Ectopic pi Other (sp	regnancy pecify)				23	d. Date of deliv Month		'ear
	w requires tha been signed I should be det	þ	Part II. Other significant conditions con	tributing to death bu	ut not result	ting in the ur	nderlying o	ause give	n in Part I.			oacco us	e contribute to to	he cause of de bably 4 □U	
Division of Vital Records,	ilcian: The law r certificate has be rector, page 2 sh	Completed								_	24a. Was a autops perform	y	death?	opsy findings a empletion of ca 2 \(\text{\text{No}}\)	ivailable iuse of
₹	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	200	R/Outpatient	- a - D	Othe			Check only on				
ò	g Phy er this eral o	<u>ان</u>	27. Manner of Death	28a. Date of Injur	v 2	28b. Time of		28c. Injury Work	4 🗀 Nursi		d. Describe ho		Other (Speci	(y)	
Ö	Attending or death.  ector: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	r rear)	Injury	м		? es 2⊡No	o					
Divis	2 # 12 E	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At hon :. (Specify)	ne, farm, stre	et, factory	y, office		281	Location (St City or Town	reet and n, State)	Number or Run	al Route Numb	78 <i>r</i> ,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred	at the time , in my op	e, date and p Inion, death	place, and occurred	d due to the ca at the time, d	ause(s) a ate and p	nd manner as s lace, and due t	stated. o the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				290	. License			2		signed (Month,		
,	2		16-14. Bu	-,1412				P 19	667			Dec	- 19 20	005	
	3		30. Name and address of person who con				Print)	2.11	-	1. 0					
	Sta	to	31. Date filed (Month, Day, Year)	22 Sauti			t r	outym	love, M	id L	1201				
	Registr	- 4	DEC 2 2 2005	Ale No	M.	1000	KI								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

VER SMI	TII			em 23a&27	of Mar 7 <b>per</b>	yland <b>me</b> G	/ Depa	artment of I AfricQte05f	lealth and		Reg. No	. U U U	41337
Physici /Medi		Decedent's Nam	16 (First, Middle	, Last)	Oliv	er S	Smith			2. Date of D Month DEC.	eath Da 7	y Year 2005	3. Time of Death 4:40 P
Examir		4a. Facility Name (		. give street and r Y STREET	-				ORE CIT	ath	40	c. County of Dea	
Funeral Director		5. Social Security 1 214-56	7959	6. Sex 1 □ M/M 2 □ F		'In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	lf Under 24 H Hours Mi	n. (Month, D	irth ay, Year, 30, 19		rthplece (State or Foreign ountry) <b>Maryland</b>
yland		Usual Residence of 10a. State	10b. County		1	Oc. City,	Town or Lo	cation					10d. Inside City Limits
with the Maryland or 28a-f ehow be notified at	Director	Maryland		N/A					Baltimore				1 ☐ Yes 2 ☐ No
ath with the 23a or 2	al Dire	10e. Street and Nu 2915 McE	<sub>imber</sub> Eldery Stre	et				10f. Zip Code	21215		10g. Ci	tizen of What C	ountry? S.A.
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Iteme 23a or 28a-f ehow ent, tra Medical Exama or must be notified at	by Funeral	11. Maritat Status 1 ☐ Never Mari 3 ☐ Widowed		Amed	ecedent Eve Forces? s 2 ☐ No Give Dates:	er in U.S.	'	Was Decedent of H IYes, specify Cub I□Yes 2□MANo	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or N arto Rican, etc.)	0-	14. Race - Am Black, Whi Specify:	
nin 72 ho In "natul Madical	Completed	(Spec		t grade complete			16a. Deced (Give life. l	lent's Usual Occup kind of work done OO NOT use retire	oation during most of w d)	rorking		(ind of Business	ŕ
led with lygiene her tha	Com	12			(1-4or 5+)			Bu	s Driver				/ School System
lid be fi fental h rked of	To Be	17. Father's Name		er W. Smith					18. Mothers N	ame (First, Middle M		Morton	
and 2 should leath and Menian 27 ie marke		19a. Informant's N Margaret		nip (Type, Print)				g Address (Street 406 Kelox Ro					Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If Itam 27 ie marked other than "natural; any injury or other traumatic event, Ita Medical Exa once.				3 □Removal from		cen	etery, cren	sition (Name of natory or other place prest Veteran	, I	Date 12/20/05	20c. L	ocation - City or Owings	Town, State Mills, Md.
permit. Departimont Import		21. Signature of Fi	uneral Service I	icensee	ton.		22	Name and Addre	Brothers Fu	neral Service Baltimore, M	, P. A.	17	
Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	artrangure. Listi (Final on	a. Athe	erosc	lerot	ic Ca	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner and I-transit	Examiner	Sequentially list confirmity, leading to incause. Enter Unde Cause (Disease or that initiated events	nmediate erlying injury	b	o (or as a c								
ficate be execut physicien and s the burial-tran	edical Ex	resulting in death)	Last	Due to	o (or as a c	onsequer	nce of):						
certif ding se a	/Med	IF FEMALE: 23b. Was deceden	at orognant	23c. If yes, o	outcome of	pregnanc	y				-1	22d Data of da	line and
at the death by the atter stached for s	Physician/M	in the past 12 1 Tes 2 Dunknown	months?		birth 2 [ gnant at time known			Ectopic pregnancy Other (specify)	,			23d. Date of de Month	Day Year
law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other signif	ficant conditio	ns contributing to	death but r	not resultin	ng in the ur	derlying cause giv	en in Part I.		tobacco u Yes 2		o the cause of death?
The ete h	Completed				- · · · · · · · · · · · · · · · · · · ·					24a. Was auto perfe 1 X Yes		prior to death?	utopsy findings available completion of cause of
ysicien: This certificete	o Be	25. Was case reference examiner? 1 X Yes 2		Hospital:	Inpatient	م ال	/Outpatient	3□ DOA Oth		eath (Check only Home 5 Res		.Y.	AT SCENE
는 는 의	-	27. Manner of Deat  1 Natural 2 Accident		28a. Dat (Mo	e of Injury onth, Day Y	28	b. Time of Injury	28c. Injur	4   Nursing	28d. Describe			cify) III SOLIT
To the Hospital or Attending & within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 4 Homicide	6 □ Could n determi	ned 286. Plac	ce of Injury Iding, etc. (	- At home Specify)	, farm, stre	eet, factory, office		28f. Location ( City or To	Street an wn, State	d Number or Ru )	ural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one)	1□ Certifying XX Medical E	xaminer: On the	he best of n basis of ex inner stated	amination	dge, death and/or inv	occurred at the time estigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To Toon	Σ	29b. Signature and	title of certifier	Hae	lav	LW	4	29c. Licens	·M.E		29d. Dat DEC	te signed (Mont	
B !		30. Name and addr	ess of person v	who completed car	use of deat	h (Item 23 11	a) (Type, F	Print) N STREET	, BALTIM	ORE, MARY	LAND	21201	
Sta Registr		31. Date filed (Mon	oth, Day, Year)		Registrar's			Conte					
MH 17 Rev 1/20	001		-UEU &	₩ <u> </u>	Control of the last	harman day							

Amend Items# 23a&23e, 24b oer PHY C854 4/24/06 CC Health and Mental Hygiene

1- For Amend Item# 16b per FH G850 12/22/05 CC Registrer amend Item# 8 Per FH G850 12/22/05 JH

1 December's Name (First Middle 1 ort) 2. Date of Death 3. Time of Death Month 2 Yeer **Physician** ANGELINE FRANCES STANLEY WOZ M 05 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITER Baltimore Dinaci Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M **X2X** F 74 Director <del>27</del>,1931 215~28~2671 Jan. Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at Maryland Baltimore County 1 ☐ Yes 🎗 🖾 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 308-I Canterbury Rd. Harford or Items 23a strilly, Angelina Funeral 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 □ Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ♥☐ No Specify: Specify: Be Completed by If Yes, Give Year or Dates: White 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Town & County than Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. 12 yrs. N/A Bookkeeper **Furniture** 17. Father's Name (First, Middle, Last) rtment of Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) Angelo Annello Ella K. Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18503 Graystone Rd. White Hall, Md. 21161 Robert C. Carrell (Son) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Importent: If any injury or Metro Crematory 12-21-05 Baltimore, Md. 11750 Belair Rd. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home Kingsville, Md. 21087 Xassahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Du mm ACUTE BRONCHOPNEUMONIA /Medical Due to (or as a consequence of): Examiner OVARIAN MUCINOUS NEOPLASM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2XXNo 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Z es 2□No 2□ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2500 To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2☐ ER/Outpatient 3☐ DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Aatural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide To the Hospitel within 24 hours a To the Funerel I \*\*Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number D33972 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or. FM2d Alorsoo 2411 W. Pollvedere of MOBH Zoie . Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DEC 2 2 2005

DHMH 17 Rev 1/2001

Registrar

	26	Registrar  1. Decedent's Name (				k Indelible In Amend I t Department of Certificate of	12	2. Date of D	eath	2005	
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CPM 05-08612 Richard Spell

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	aryland		artment of rtificate of	Death	мептат ну	GIERI Reg. No		)	413	4
	Dhysisi	on	Decedent's Name (First, Middle	e, Last)					2. Date of De			ear	3. Time of I	Death
	Physici /Medi		PETER	RICHARD	SPE	ELL			Decemb	er 2	20 <b>,</b> 20	05_	12:04	· P
	Examir	er	4a. Facility Name (If not institution			_		or Location of Deal	th	40	c. County of E	Death		
	Funeral Director		University Hosts. Social Security Number 237–24–5566 Usual Residence of Decedent	6. Sex 7. A		ast birthday) Yrs.	If Under 1 Year Months Days			ay, Year,		Birthpl Coun NO	place (State or otry) C	r Foreign
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation					11	0d. Inside Cit	y Limits
	e Mar	ctor	MD		BAI	LTIMOR	E						XXYes	2 🗌 No
	ath with th	ral Director	10e. Street and Number 1133 N. CAREY	STREET			10f. Zip Code 2121	7		10g. Ci	itizen of Wha	t Coun SA	itry?	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f ehow amy injury or other traumatic event, if a Medical Evaruh at must be truffled at ODGs.	d by Funeral	11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced	If Ves Give	? No	[	1□Yes 2√∏ No			)-	14. Race - A Black, V Specify:[B]	White, 6	etc.	
5	"natu	lete	15. Deceder (Specify only highe	t's Education st grade completed)		16a. Deced	dent's Usual Occu	pation during most of wo ed)	rking	16b. F	Kind of Busine	ess/ind	dustry	
12	withir lene. then tre M	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		anitor	9 <i>0)</i>		A	AUTOMOI	BILI	E	
5	al Hyg	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maidei	n Sumame)			
<u>کا</u>	ould b Menta arked atice	To		ELL				ALM	IA SP	ELL				
Maryland	d 2 sh th and 7 te m traum		19a. Informant's Name/Relations THERESA SPELL/					t and Number or Re EY STREET		-			Code)	
Baltimore,	eges 1 an ant of Heal it: If item 2 y or other	8	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S	3 □Removal from State	20b. Pla ce GAF	ace of Dispo	sition (Name of	V. A. 12-2	Date	20c. L	ocation - City	y or To		-
Baltir	permit. P Depertme importan eny injur	(	21. Signature of Funeral Service					ess of Facility JA						, INC
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cause	d the death.						,		Approximate Interval Betw	yeen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		lenoti	c care		ar desec					Onset and D	
	Examiner	16	Sequentially list conditions,	b. Due to (o. as	· · · · · · · · · · · · · · · · · · ·	=000 of								
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G		31.00 31,1								
68760,	tificate be executed og physicien and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as	a consequ	ence of):								
	ertificat ling phy e as th		IF FEMALE:											
P.O. Box	The law requires that the death cert sie hes been signed by the ettendin page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3□	Ectopic pregnand Other (specify)	ey .			23d. Date of Month			'ear
	quires that n signed b ud be deta	þ	Part II. Other significant conditi	ons contributing to death I	out not resu	lting in the ur	nderlying cause g	ven in Part I.					ne cause of de	
Division of Vital Records,	The law rec te hes bee age 2 shot	Completed								psy ormed?	prior deati	r to com th?	psy findings a npletion of ca	vailable use of
<u>ra</u>	ician: Th certificete rector, pag	BeC	25. Was case referred to medica examiner?	2 10 2 2 2				26. Place of Dea	1 ≥ Yes ath Check only		101	105	2□ No	-
<u>&gt;</u>	Physic this ce al direc	ို	1 ZYes 2 □ No	Hospital: 1 ☐ Inpati		R/Outpatien	1 3 DON		lome 5 ☐ Resi			Specify	9	
sion o	Attending Physician: or death. ector: After this certifically the funeral director, it	Certification:	27. Manner of Death  1   Natural  2  Accident  3  Suicide  6  Could	gation	iry ny Year)	28b. Time of Injury	We	ryat ork? ]Yes 2 □No	28d. Describe	how inju	ry occurred			
Ž	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page		3 Suicide 6 Could 4 Homicide determ	ined 286. Place of In	jury - At hor tc. <i>(Specify)</i>	me, farm, stre	eet, factory, office		28f. Location ( City or To			r Rural	Route Numb	er,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifyin (Check only one) Medical	ng Physician: To the best Examiner: On the basis of and manner si	or examinati	vledge, death on and/or inv	occurred at the treatment occurred at the treatment of th	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s date an	) and manne d place, and	r as sta due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifie				Į.	se number			ate signed (M		-	
	, )		Jasho	greet	n	(D)	(	C.M.E.		Dec	cember	21	, 2005	
h	of or		30. Name and address of person Tash a Z Gree	ubery M.D.		111		eet, Bal	timore,	Mary	land 2	2120	01	
	Sta Registr		31. Date filed (Month, Day, Year, DEC 2		rar's Signati		(needs)					_		

Leslie Logan-Smith 05-08515 d1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend/Inpend item: 31,23a,27, penvis of Hoolth and Mental Hygiene

			For State Registrar	State of Mai	_	Cer	tificate of				Reg. No.	005	5	1342
	Physici		Decedent's Name (First, Middle, La.      LESLIE	st) Leslie Lo LOGAN	gan-Smit	h <del>-SM</del> T	LTH-			Date of De Month Decemb	David	7 2	005	3. Time of Death 4:15 P M
	/Medic Examin		4a. Facility Name (If not institution, given Sinai Hospital				4b. City, Town, o			- CCIII		County of		7.17 1
24	Funeral Director			THE AME	(In yrs. last bii O	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Bin (Month, Da LB 2	th Year) I' 196	55	9. Birthpl Coun	lace (State or Foreign try) MD
	Maryland e-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, Tow BALTIM		cation						10	0d. Inside City Limits 1 A Yes 2 No
	th with the 23a or 28 set be no	al Director	10e. Street and Number 3905 FERNHILL	AVENUE			10f. Zip Code 2121	.5			10g. Citiz	en of Wh	at Coun	try?
920	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "naturel", or lieme 23a or 28e-f ehow event, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cub	lispanic Orig an, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No an, etc.)			White, e	
Maryland 21215-0036	within 72 h ane. than "natu he Medical	mpletec	15. Decedent's Elementary/Secondary (0-12)			Deced (Give i life. D	lent's Usual Occup kind of work done OO NOT use retire	ation during most d)	of working			d of Busi		ON CENTER
צ פר	I Hygi other	Be Co	17. Father's Name (First, Middle, Last)					18. Mother	's Name (Fi	rst, Middle,				ON CENTER
ylar	should be nd Menta marked matic ev	To	OLLIE LOGAL	Control of the Contro				BEAT			LTT			
Mai	and 2 sheath and n 27 is n	1	19a. Informant's Name/Relationship ( WARREN ALFORD/BI		19b		g Address <i>(Street</i> 27 NORTHO							
Baltimore,	of H		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)	Removal from State	cemete	f Dispos ry, crem	sition (Name of natory or other plac CEMETERY	е)	Date 2/22/C			cation - C	ity or To	wn, State
Balti	permit. Page Department Importent: If eny injury or		21. Synat re of Funeral Service Licer	see	m	22.	Name and Addre		JAMES					F.H., INC
	tificate be executed // Medical Examiner as the burial-transit	ledical Examiner	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a)	erotic Consequence	of):	er the mode of dyin	ig, such as c						Approximate Interval Between Onset and Death
O. Box	death cer e ettendir d for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death		Ectopic pregnancy Other (specify)	,			23	3d. Date (		ry Day Year
7	The law requires that the the has been signed by the hage 2 should be detached.	þ	Part II. Other significant conditions of	ontributing to death but	not resulting i	n the un	derlying cause giv	en in Part I.		23e. Did to	1	/		e cause of death?
Vital Records,		Completed						······································	_	24a. Was autop perfo Yes		dea	re autop or to com atb? Yes	esy findings available apletion of cause of
VII V	ilcian: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (CI					
on of	Attending Physician: r death. sctor: After this certific by the funeral director.	ıtlon: To	15 Yes 2 No  27 M nner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b.	itpatient Time of njury	28c. Injur	4 U Nuis		5 Resid				
Division	al or Attends efter death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		ırm, stre	eet, factory, office		28f.	Location (S City or Tow	Street and vn, State)	Number	or Rural	Route Number,
	Tistin Hospital or A within 24 hours efter To the Funeral Direct Completely filled in by	Medical (	2 Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	y wrian. To the best of niner: On the basis of e and manner state	xamination an	daeth id/or inv	occurred at the tirestigation, in my o	na, date and pinion, death	place, and occurred a	dea to the t	date and p	place, and	at as sta due to	the cause(s)
13	within 2	Σ	29b. Signature and title of certifier	- ( de - n	LAAO		29c. Licens				29d. Date	signed (i	Month, D	lay, Year)
1	$\langle \  $		30. Name and address of person who	completed cause of dea	th (Item 23a)	(Type, f	OCME			D	<u>ecemb</u>	ber 1	L7,	2005
	1		MARGARITA	D. KUREL			111 Penn	Stree	et, Ba	1timo	re, N	Mary]	Land	21201
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2	2005 32. Registrar	s Signature	J.	brest							

DHMH 17 Rev 1/200

Registrar

			1 - State Amend Item#17	State of Marylan cer INF G852	2/13/6	rtment of H 6 CC tificate of L	ealth and N Death	Mental Hygi	ene 005	1 4 1 3 4 4
	Db		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	)	3. Time of Death
	Physici /Medio		Donald James Spron	9					Day Yea 2005	10:45 AM
	Examin	er	4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of De	ath
			2723 Singer Woods			Abin		T		ford
4	Funeral Director		130-01-3470	7. Age (In yrs. 85	Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 31,	1920 N	lirthplace (State or Foreign Country) ew Jersey
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	tor	MD Harford		Abing	don				1 ☐ Yes 2√ No
	or 28g	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a	rai	2723 Singer Wood	s Drive			21009		USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Timportant: If term 27 is marked of they than "naturel", or items 23a or 28a-f show any finjury or other traumatic event, the Medical Exameter must be notified at once.	Completed by Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	. Was Decedent Ever in U. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: WW I	_   '	Vas Decedent of His Yes, specify Cubar ☐ Yes 2  ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
2	72 ho	ted	15. Decedent's Educa	tion	16a, Deced	ent's Usual Occupa	tion	. 1	6b. Kind of Busines	s/Industry
2	ithin 7	nple	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done d OO NOT use retired)	uring most of work	ang		
2	led wi lygien her th	Cou	12	0	ex	ecutive				ufacturing
and	ould be fi Mental H Marked otl	Be	17. Father's Name (First, Middle, Last)  Albert Sprong	161 0				e (First, Middle, M	aiden Sumame)	
Ē	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (Type	1fred Sprong		a Addrose (Street a		Van Ness	City or Town, State	7'- Carlot
Z Z	and 2 sealth arm 27 is ner trau	1	Deborah Sprong/day			Singer Wo				1009
altimore,	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☑ Donation 5 ☐ Other (Specify)		lace of Disposemetery, crem	sition (Name of natory or other place	) l	Date 2	0c. Location - City o	or Town, State
Balt	permit. Page Department. Important: If any injury or		21. Signature of Funeral Service Licensee Ronald S. Wa	de ixector	St Ba	Name and Address ate Anato ltimore,	s of Facility my Board MD 2120	655 W. 1	Baltimore	Street
i i	Physician		23a. Part1. Anter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the death cause on each line.				or respiratory arres		Approximate Interval Between Onset and Death
8	/Medical Examiner		resulting in death)	Due to (or as a consequ			•			1
		ē	Sequentially list conditions, b.	Due to (or as a consequ	SWILL					
	nted Insit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to tot as a consequ	2611C6 O1).					
-	cate be executed physician and the burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
09/8	te be ysicia ne bur	dical	d							
0	ng ph	Medi	IF FEMALE:							
XOR	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnal	death 3	Ectopic pregnancy			23d. Date of do	elivery Day Year
oj.	at the de by the a tached t	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	∍am 5⊔	Other (specify)				,
S,	gned be de	by Pt	Part II. Other significant conditions contri	buting to death but not resu	ılting in the un	derlying cause giver	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
or o	w requir been si should	ted						1 🗆 Yes	2 □ No 3 □ F	Probably 4 🗀 Unknown
	The la ate has page 2	Completed						24a. Was an autopsy performe	eath?	autopsy findings available completion of cause of s
VITal		o Be	25. Was case referred to medical examiner?	pital:		Other	r-	(Check only one)		
0	r this	$\vdash$	100 20010	I U Inpatient 2 U I	ER/Outpatient 28b. Time of	3□ DOA 28c. Injury	4   Nursing Ho	me 5 A esiden 28d. Describe how	ce 6 Other (Sp.	ecify)
0	tending Phileath. tor: After th	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	es 2 □ No	200. 0000100 11011	inquity occurred	
UNISION	r Atter er dea rector by the	Certification;	2 Suiside 6 Could not be	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or F	Rural Route Number,
	ital o rrs aft raf Di	Ce								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	fedical	one)	an: To the best of my know : On the basis of examinat and manner stated.	wiedge, death ion and/or inv	estigation, in my opi	nion, death occurr	and due to the cau ed at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	Mit Con.	2	29b. Signature and title of certifier  Mark Lame			D 3x	53	290	Date signed (Mon	
حني ا			30. Name and address of person who comp			Illing Rd	). Hu	nt Valle	CM P	21030
16/2	Stat Registra	_	31. Date filed (Month, Day, Year)  DEC 2, 2, 2005	32: Registrar's Signat	A SAM	(i)				

			1 - For State Registrar	State of Maryland		artment of H			erte 0 0 5	41345
	Q .		1. Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physici /Medio		GENEVA S	KINNER				DEC	Day Year	5 2:30 P M
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Deat		4c. County of Dea	
			SOMERFORD PLA	CE		COLUN	nBIA .	mb .	HOWAR	CLS
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day July 19	(Year) 9. Bir	thplace (State or Foreign ountry)
	Director			<sup>1</sup> 2 XX 86	Yrs.	Wientile Bays	Tiodio William	July 19	, 1919 Was	shington DC
	and *		Usual Residence of Decedent  10a, State 10b, County	10e City	, Town or Lo	cation				10d. Inside City Limits
	sho	ក		100.00,						1 Yes 2 No
	the A	Director	Maryland Howard  10e. Street and Number		Coli	ımbia		40	0.00	
	a or					10f. Zip Code	045	10	g. Citizen of What Co	,
	ours after death with the Marylan raf', or Itams 23a or 28a-f show Examirer mast be notified at	Funeral	8220 Snowden Ri	. Was Decedent Ever in U.S	12 1	Vas Decedent of Hi		posifu Ves es Ne	United St	
	ter d	in I	1 Never Married 2 Married	Armed Forces?	J. 13. Y	f Yes, specify Cuba	n, Mexican, Puer	o Rican, etc.)	Black, Whi	
336	urs ai	by	3X_Widowed 4 □ Divorced	1 ☐ Yes 2 TVNo If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specify:		Specify: W	hite
Ā	2 hc	Completed	15. Decedent's Educa	tion	16a. Deced	lent's Usual Occupa	ation	1	6b. Kind of Business	
215	d within 7. piene. r than "n the Medi	ple	(Specify only highest grade ( Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give l life. E	kind of work done of OO NOT use retired,	luring most of woi )	rking		,
21	d wit	NO.	12	35.1095 (1.10.01)		Sales			Hecht Co	ompany
g	be filed htal Hygie od other avent, II	Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
<u>X</u>	2 should be and Mental is marked c	To I	Charles	Ralph White				Beulah Ta	ylor	
, Maryland 21215-0036	ges 1 and 2 should it of Health and Mer If itam 27 is marke or other traumatic		Jeanne S. Morck,		19b. Mailin 12335	g Address <i>(Street a</i> Pleasan	nd Number or Ru t View D	ral Route Number, rive, Ful	City or Town, State, . ton, MD 2	Zip Code) 20759
Baltimore,	of Hei		20a. Method of Disposition 1 □ Burial 2/ Cremation 3 □ Rea		ace of Dispos	sition (Name of natory or other place	9)	Date 2	0c. Location - City or	Town, State
Ĕ	Pages nent of I ant: If its ury or o		'4 ☐ Donation 5 ☐ Other (Specify)		Crema	ntory Dec	19 2 00	5 C	linton, Ma	arvland
a	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	1 .	22	. Name and Addres	s of FacilityLee	Funeral	Home, Inc	6633 Old
<u> </u>	8 9 E 8 9		Mienton D. Ju	less moiz	- /					land 20735
F			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death.	Do not ente	er the mode of dying	g, such as cardiad	or respiratory arres	st.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASPIRAT			moni			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque		11000	711(01011			2 0023
	Examiner		Sequentially list conditions b.	DYSPHA	CUA	1				2 weeks.
1	ש ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):	, 5				
V	ecute and trans	am	that initiated events c. resulting in death) Last	HLZHEIT		i De	menn	1		3 years.
60,	be executed ician and burial-transit	E	Toodking in doubly Edge	Due to (or as a conseque	ence of):					,
8760,	cate be execu physician and the burial-tra	dical	<b>d</b> .							
9 x		/Me	IF FEMALE:	. If yes, outcome of pregnan						
Вох	eath certif attending for use as	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 🗌	Ectopic pregnancy			23d. Date of de	livery Day Year
o.	that the de ed by the detached	Physiclan/Me	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9 Unknown	atn 5	Other (specify)				
σ.	that the	F.	Part II. Other significant conditions contr	buting to death but not resul	Iting in the un	deriving cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records	bed bed	Completed by	Hyperrension					1 ☐ Yes	2 1 No 3 □ Pr	obabły 4 Dunknown
20	≥ <u>□ ™</u>	ete						240 1460 00	0.45 14/	
Re	as as ca	mp						24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of
B		e Co	25. Was case referred to medical					1 ☐ Yes 2	ØNo 1□Yes	2 🗆 No
		o Be	examiner?	spitat: 1   Inpatient 2   E		Othe		th (Check only one)		11
of	를 를 <mark>급</mark>	$\vdash$	27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	3 DOA 28c. Injury	4   Nursing n	ome 5 Hesiden 28d. Describe how		city) HOSPICE.
on	ding Ph th. : After th s funeral	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	? ′es 2 □ No		injury coocines	
Division	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	ne, farm, stre	eet, factory, office			et and Number or Ru	ural Route Number,
Ö	afor safte Dire	Certification:	4 Homicide	building, etc. (Specify)		•		City or Town,	State)	·
	To the Hospital or Attenc within 24 hours after death To tha Funaral Director: completely filled in by the I		29a. Certifier 1 Certifying Physic	ian: To the best of my know	rledge, death	occurred at the time	e, date and place	and due to the cau	se(s) and manner as	stated.
	the H in 24 the Fi	edical	one)	r: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death occu	rred at the time, dat	e and place, and due	to the cause(s)
	with To T	Σ	29b. Signature and title of certifier	0		29c. License			d. Date signed (Monti	
)			Toshem	-hm		242	2680	D	EC 19, Lucon-Cir	2005
	1		30. Name and address of person who com	pleted cause of death (Item :	23а) (Туре, Р	Print)	0 0			
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• -	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 201	32. Hagistrar's Signatu	M. La	Soll				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 20c per fh g850 12-22-05 vt. State of Maryland / Department of Health and Mental Hygiene 15 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HILDA STEINHARTER DECEMBER 20 2005 РМ 1:28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 2QF 348-12-1999 86 Yrs 11/23/1919 GERMANY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 ☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3916 LABYRINTH ROAD 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ISIDOR STRAUSS ROSA GOTTSCHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNIE STEINHARTER/SON 3918 LABYRINTH ROAD - BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Rosedale City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CHOFETZ CHAIM 12/21/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Acute Renal Failure (exacerbation) cays. Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diubeters mellitus 2 PNo 1 🗌 Yes 3 Probably 4 Unknown Chrinic nend FAILURG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ANEMIA 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of fnjury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

/Medical Examiner The law requires that the death certiticate be executed Division of Vital Records, P.O. Box 68760, Hospitel or Attending Physician:

**Physician** 

/Medical

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init. Pages 1 and 2 should be filed within 72 hours after death effenent of Health and Mental Hygiene.
critent: If Item 27 is marked other than "natural", or Iteme 23, miury or other traumatic event, the Medical Exert an mulay or other traumatic event, the Medical Exert are mula.

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Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year)

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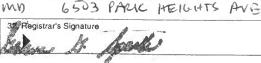
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COOPER

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

WW



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12/21/05

BALT. MM 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #1 Per PHY C850 12/28/05 JH Death

1. Decedent's Name (First, Middle, Last)

Jimnie Sue Toal 2. Date of Death Month Day Year **Physician** OAL DECEMBER219 12=09 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ita z ford UPPER EHEJAPEARE MEDICAL CENIER STLATIL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 425-40-5742 01/03/1927 Alabama Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 800 Karylou Circle 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be and Mental I James Forest Spencer Ethel Brigans Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 800 Karylou Circle - Kingsville, Maryland Robert L. Toal, Sr. (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State ö Department of Importent: If it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdns. 12/23/05 Fallston, Maryland
22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 67 11750 Belair Road - Kingsville, Maryland asseln 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE TRAUMAIL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACCIDENT MOTAR JEHICULA2 Sequentially list conditions day, leading to immediat cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an AVGNOMA autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1√Yes 2 No 1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred that 2 5 cla 27. Manner of Death 28b. Time of Certification: After Division Hospitel or Attending 1 Natural 5 Pending 11=45 APAL, 1 Yes 2 No investigation death 2 Accident 281. Location (Street and Number or Ritral Route Number, City or Town, State) 12-14-2005 NB OLF Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Rti Fallston n D 21047 HA 2TI /MILIONAU FAllston 21047 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the Ithin 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 0 0 21809 DESEMBER 14, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

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			T = For State Registrar	State of M	aryland /		tment of F ficate of I	lealth and I <i>Death</i>	Mental Hy	/giene	05	41348
	D	1	1. Decedent's Name (First, Middle, La	ist)					2. Date of De	eath		3. Time of Death
	Physici /Medi		Joseph A. Tates						Decemi	BER 3	2005	- 14:26 M
1.	Examir	ier	4a. Facility Name (If not institution, gire	1.	-	4	b. City, Town, or	Location of Death		4c. Cot	inty of Death	
1			SAINT AGNE			1:44 1 1	BALTIN	nort	T			
	Funeral Director			Sex 7. A	ge (In yrs. last i		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. Jan 31	av. Year)	Cou	place (State or Foreign intry) Land
	land ow		10a. State 10b. County		10c. City, To	own or Locat	ion					10d. Inside City Limits
	Mary fied	tō	MD		Bal	ltimor	e					1√ Yes 2 No
	h the	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
	th wit	aiD	4206 Colborne Ro	ad			2	1229			USA	
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces		13. Wa	s Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No	o- 14. F	Race · Ameri	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. I have matural, or Items 23a or 28a-f show event. The Medical Examinar must be inclified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	No	10	Yes 2 No	Specify:	rnean, etc.)		ocity: $b1$	
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation		6a. Deceden	t's Usual Occupa	ation		16b. Kind o	f Business/Ir	ndustry
2	within 72 ene. than "nat	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	NOT use retired	during most of work d)	ang			
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and and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	e (First, Middle	, Maiden Sun	name)	•
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Maryland	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship Alice Tates/spous					and Number or Rui Road Bal				o Code)
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Baltimore,	Page: ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Special Control of Cont	(y)	ceme	tery, cremate	ory or other plac	θ)				own, oldio
Bai	permit. Pag Department Important: I any Injury o		21. Signature uneral Service Lice Ronald S.		efter	Sta	ame and Addres te Anato timore,	omy Board	655 W.	balti	more S	Street
€.	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do					rrest,		Approximate Interval Between
М	Physician		Immediate Cause (Final disease or condition	Atho	6-5-10	- t	- has	wt di	Sa 4 Sa			Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consequenc	ce of):	Citer	MI CH	JEAJE			2 years
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	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or se	a consequence	a of						
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68760,	phys s the	edical		_ d							-	
Вох (			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					224	Date of delive	on
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	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death b	out not resulting	g in the under	rlying cause give	n in Part I.	23e. Did t	obacco use co	ontribute to t	he cause of death?
ord	w require been sig should b		lung	concer					1 🗆 '	Yes 2□No	3 Prob	pably 4 Unknown
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ot	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Inju	ry 28b.	. Time of	28c. Injury Work	4   Nursing Ho	me 5 ☐ Residente la 28d. Describe la 28d.			y)
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	s afte sall or	Cert	4 El Homolog	building, et	c. (Specity)				City or Tox	wn, State)		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	nysician: To the best niner: On the basis o and manner st	t examination a	ge, death oca and/or invest	curred at the tim igation, in my op	e, date and place, inion, death occurr	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		29d. Date sig	ned (Month,	Day, Year)
	_		Kuran Hm and	" Allen	1:	his		20061564	ı	12/13	105	
			30. Name and address of person who	completed cause of c	leath (Item 21a	) (Type, Prin	t)			1-113	102	
			Ryan Howa	12 900	CAtan	Are	, BAIT	imore,	40 2	1229		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1	10.	-				
	Registr	ar	DEC 2 2 200	5 Bearing	. B. A	GOSAL.	1					

			1 - For State Registrar	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 5	41349
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La     Novwa      Aa. Facility Name (If not institution, given	Month Day 18 20	3. Time of Death
	Funeral Director		Northwest House 6.5 Social Security Number 6.5	OSPITAL CENTER RANGALISTOWN BAITINGS SENT 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth 9. Birth	nore place (State or Foreign ntry)
	pu ,	tor	Usual Residence of Decedent  10a. State 10b. County		10d. Inside City Limits 1 Yes 2 □ No
	ath with the 128 or 28 or 28 or 128 o	Funeral Director	10e. Street and Number 7004 A(c	den Rd. 101. Zip Code 10g. Citizen of What Cou	4
5-0036	7.72 hours after death with the Maryland "neturel", or items 23e or 28e-f show adjoal Examit withheat the confiding at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces?  1	
21215-(	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other treumetic event, the Medical Evant incrinative rotifical any injury or other treumetic event, the Medical Evant incrinative rotifical and once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		dustry 3 orking internet
Maryland	2 should be file and Mental Hy is marked oth sumetic event	To Be (	17. Father's Name (First, Middle, Last	Nilson Louise Doughty	
-	es 1 and 2 sh of Health and f item 27 is n r other treun		19a. Informant's Name/Relationship (	-aunt 5 Panacea Ct, Bactmare md, 2  20b. Place of Disposition (Name of Date 20c. Location - City or T	208
<b>Baltimore</b> ,	permit. Pages Department of I Importent: If its any injury or o		1 Burial 2 Cremation 3 C Other (Speci	King memoral PK: 12/24/05 Kandallsto	wn, md.
	Physician /Medical		23a. Parti. Enter the disease, or conshock, or heart failure. List only immediate ause (Final disease or condition resulting in death)	a. A Lie of the second of the consequence of:	Approximate Interval Between Onset and Death
8760,	Examine be executed hysician and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d	
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown	ery Day Year
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of Vital Records,		Completed		24a. Was an autopsy performed? 1 \( \text{Yes} \) 2\( \text{V} \) No 1 \( \text{Yes} \)	psy findings available mpletion of cause of
	ys dii	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Month, Day Year)  28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred	v)
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_	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical Co	29a. Certifier (Check only one)  1 Certifying Pl	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	ated. the cause(s)
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	Sta Registi		31. Date filed (Month, Day, Year)  DEC 2 2 2	32. Registrar's Signature 2005	•

			For State Registrar	State of Maryland / Department Ce	artment of Health and rtificate of Death	Mental Hygie	(1113 413311
	Physici /Medio Examin	al .	1. Decedent's Name (First, Middle, Last,  HCLC  4a. Facility Name (If not institution, give	Marie Whee	4b. City, Town, or Location of Deat	2. Date of Death Month	Day Year 3. Time of Death 12.30A, M
	Funeral Director		Hart Heritag 5. Social Security Number 6. Sel 220-09-4081.		If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	HARFORD  9. Birthplace (State or Foreign Country)  9.19 MARYLAND
	the Maryland 28e-f show	rector	10a. State 10b. County  Harfor  10e. Street and Number	10c. City, Town or Lo	ocation 1 S + O N 10f. Zip Code	10g.	10d. Inside City Limits 1 ☐ Yes 2 No  Citizen of What Country?
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any figury or other traumatic event, the Medical Exart an invitio at miffied at once.	y Funeral Director	1 Never Married 2 Married	1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 the Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours iene. then "neturel", the Medical Ex	Completed by	3 D Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)	Year or Dates:    cation   16a. Dece   (Give   life.   dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b	Kind of Business/Industry	
Maryland 2	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last)  William Law ( 19a. Informant's Name/Relationship (Ty	ince Leo Rose		me (First, Middle, Maid abeth T ural Route Number, Cit	Tatnall
Baltimore, M	Pages 1 and 2 nent of Health a ant: If item 27 Is ary or other tra		20a. Method of Disposition  1 MBurial 2 Cremation 3 The Company of the Company of	1-daughter 2111 20b. Place of Dispo cemetery, cre- la r CWO	Sivens wood I sition (Name of matory or other place)	6	Location - City or Town, State  ALTIMORE MD
Balt	permit. Departr Imports any Inji		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease or compleshock, or heart failure. List only or	ee 101111 2	2. Name and Address of Facility  LANS FUN FURAL (	TIMORE, 1 HAPEL SX	MO 21234.  MO HAR FOR IO RO  Approximate Interval Between
	Physician /Medical Examiner	16	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):  Due to (or as a consequence of):	ION.A		Onset and Death  Y W/ US
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause. Enter Underlying	Due to (or as a consequence of):			
Box 6	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that s been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death but not resulting in the u			o use contribute to the cause of death?  2 No 3 Probably 4 Junknown
Division of Vital Records, P.O.	cien: The law ertificate has t ector, page 2 s	Be Completed	25. Was case referred to medical examiner?			24a. Was an autopsy performed 1 Yes 2 1	No 1 Yes 2 No
sion of \	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	27. Manner of Death   Natural   5   Pending investigation   3   Suicide   6   Could not be	ospital: 1 Inpatient 2 EP/Outpatier  28a. Date of Injury (Month, Day Year)  28b. Time o Injury	f 28c. Injury at Work? M 1 Tyes 2 No	lome 5 Residence 28d. Describe how in	jury occurred
Dİ	Hospital or At 4 hours after of Funerel Direct Bly filled in by	edical Certifi	4 Homicide determined  29a. Certifier Check only 2 Medical Exami	28e. Place of Injury - At home, farm, str building, etc. (Specify) sician: To the best of my knowledge, deat ner: On the basis of examination and/or in	h occurred at the time, date and place	City or Town, Sta	(s) and manner as stated
	To the living 24 to the formula complete	Med	29b. Signature and title of certifier	and manner stated.	20c License rumber	204 (	Date signed (Month, Day, Year)
	Sta	te	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print) - MACPARI P		
F	Registr		DFG 2 2 21	AP	and I		

	1	State of Maryland / Department of Health and N  - For State - Registrer  Certificate of Death	Mental Hygi	ene 005	41352
		Registrer  1. Decedent's Neme (First, Middle, Last)	2. Date of Death	g. No.	3. Time of Death
Physiciar /Medica		MARGARET WATSON	DEC.	Day Peer -	8:10 M
Examine	r '	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	15 13
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALT, MI	
Funeral Director		2/2 - 7/6- 540 1 M 2/2 F Q2 Yrs. Months Days Hours Min.	Month, Day	Year) Cour	plece (State or Foreign
		Usual Residence of Decedent	1400 001	7 [ ]	
yland		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
A Ma	25	MD. BALIV TOWSON			1 Yes 2 HNO
F 128	E	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
death with the Maryland ms 23a or 28a-f show rmst be notified at	2	7001 N. CHARLES ST. 21204		U.5.11	
after or Its	by runeral Director	11. Marital Status  1	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	
Do non I		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	1	6b. Kind of Business/In	HIE dustry
d 21215- filed within 72 Hygiene. other than "na ont, the Medic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king `	1.4	
212 I with Jiene.	Ē	Elementary/Secondary (0-12) College (1-4or 5+)		UNK	الم لا لا لا لا لا ال
D ETSE	Dec	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, M	laiden Sumame)	-3
irylar should be ad Menta marked matic ev	0	UNKHOWN	NKUEL	الم نو	
Maryla d 2 should th and Men i7 le marke traumatic	J	19a. Informant's Name/Relationship (Type, Prop SALY) 19b. Mailing ddress (Street and Number or Run	-	CONCLETE CO.	Code)
C = 64 F		DEDT OF AGING PRAYER GILLENIAN AVE	BALTI	1	1204
More Pages 1 nent of Hi int: If Itan		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	Cocation - City or To	own, State
	F	'4 □Donation 5 □ Other (Specify)  21. Sinature Funeral Service Licensee  22. Name and Address of Facility	1005	5440	MD.
Balt permit. Departi Import any inj pnce.		Homas Skardan SKARDA F.H.	34150	MD 712	716
- 1	$\top$	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition (ARTIAC ARRAY THM / A	7		Onset and Death
/Medical		resulting in death)  Dui to (or as a consequence of):			JMM
Examiner		Sourcetially list anothings b CONGESTIVE CARDII	AC F	AILURA	5 YEARS
P # 1	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	24 Da	CE ADIC	LAVEARS
and -trans	Examiner	Cause (Disease of Injury that infiliated events resulting in death) Last  Due to (or as a consequence of):	1 20	2.51.2.	0 (12/17)
Dur Dur	Cal	bue to (of as a consequence of).			
687 ificate g phys as the		d.			
Box (	2	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant		23d. Date of delive	эгу
death death be atternated for	by Physician/med	in the past 12 months?  1		Month	Day Year
P.O		9 Unknown			
Hecords, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	dob	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the 2 No 3 Prob	ne cause of death?
w req	Completed	MENTAL RETARDATION	24a. Was an	24b. Were auto	psy findings available
al Rec	E		autopsy	ed? death?	mpletion of cause of
	a)	25. Was case referred to medical 26. Place of Deat	th (Check only one		2010
Of Vita Physician: this certific at director,	0	examiner?  1 Yes 25 No	ome 5 Resider	nce 6 Other (Specif	y)
ng Ph (fter th		27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Injury Work?	28d. Describe how		
SIO leath. for: A	Cati	2 Accident investigation M 1 Yes 2 No			
DIVISION OF or Attending Phy after death. Diractor: After this d in by the funeral d	Certification	determined  4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rura State)	il Route Number,
2 S 2 9		29a. Certifier  (Check only  (C	, and due to the cau	use(s) and manner as s	tated.
the the the the the the the the the the	Medical	and manner stated.  29b. Signature and title or certifier  29c. License number		d. Date signed (Month,	
T Will	1	RAMAJUAhOPACAN M.) 05122		12/11/2	1005
0.			16	7 RATIO	10 RH2
1		30 Jame and address of person who completed cause of death (Item 23a) (Type, Print)  RENT NA CROSS PO	H 2040	5) 07 21	228
State	-	31 Date filed (Month, Day, Year)  32. Registrar's Signature	1		
Registral		DEC 2 2 2005   American At Specific			
2/11/11/17 nev 1/200	1	ORIGINAL			

			State	of Maryland					ne.	1 0 5 0
		1	For State Registrar	Ormanyland		ate of De		Reg.	ZUU D	4   353
B. 18 1 1 1			Decedent's Name (First, Middle, Last)		0			. Date of Death	_	3. Time of Death
	Physicia		THEODORE	C.	11/1	LKER		DEC. (	pay 2005	2:10 M
	/Medic Examin		la. Facility Name (If not institution, give street and	number)	4b. 0	City, Town, or Lo	cation of Death		4c. County of Death	1
	Examin	٥.	JOSEPH RICH	E House	SE 1	BALTII	MERE		DIA	
30	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) If Un Mon	nder 1 Year If		Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreign
	Director		219-86-8229 1EM 20	44	Yrs.	Days	1	VEV. 12,	1961	VA.
P		-	Usual Residence of Decedent	100 City	Town or Location					10d. Inside City Limits
arytar	show		10a. State 10b. County	Toc. City,	TOWN OF ECCATION	1.				1 € 165 2 No
. W	Ba-f	ecto	17D. P/1	1217	-6/1/1/	Zip Code		100	Citizen of What Cor	intry?
Aih ti	Nor 2	급	10e. Street and Number	Dank.	A:W	1 , 1 /	,	l log.	11.5.M	4
aath	a 23	by Funeral Director	3309 W: FORES!	Decedent Ever in U.S.	13. Was D	ecedent of Hispa	anic Origin? (Speci	fy Yes or No-	14. Race - Amer	ican Indian,
ter d	P E	Ę.	Ame	Forces? es 2 (DNo , Give		./	anic Origin? (Speci Mexican, Puerto Ri	ican, etc.)	Black, White	, etc.
<b>5-0036</b> 72 hours after death with the Maryland	le E	by	3 ☐ Widowed 4 ☐ Divorced	, Give or Dates:	1 □ Ye	s 2 No S	Specify:		Specify: BL	ACK
5-0 72 ho	atur Eal	Completed	15. Decedent's Education (Specify only highest grade complete	redi	16a. Decedent's	Usual Occupation	n na most of working	166	. Kind of Business/	ndustry
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yla outd t	and Mental Is marked aumatic ev	ဥ	HERBERT LEE	WALK	ER	/-	VIR	G-1 DIA	TOX	- man MD
Maryland	ls m		19a. Informant's Name/Relationship (Type, Print)	w.A	2200	ress (Street and	Number or Hural	Drak I	ty or Town, State	2/2/6
	if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at	-	20a. Method of Disposition	20h. Pla	ce of Disposition	(Name of	Da	te 200	Location - City or	
OL Se	or of		1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal for	000	netery, crematory	or other place)	DEC	9- 4	7	J I'D
Baltimore,	Depertment o Important: If any Injury or QDCE.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Dh	7/ / / El	e and Address	M. 2	009 13	1740 )	MY.
Balt permit.	Depertm Importa any Inju once.		21. Signature of Porteral Service Licensee	Shee Le 8	SIL	niDDH /	-//. ×	829 1	UD DE	1224
¥.			23a. Part1. Enter the disease, or complications to	nat caused the death.	Do not enter the	mode of dying,	such as cardiac or	respiratory arrest	) 1-12-29	Approximate Interval Between
			shock, or heart failure. List only one cause	on each line.	2					Onset and Death
	ysician Medical		disease or condition resulting in death)	e o (or as a conseque		incer				145
E	caminer									·
7		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a conseque	ence of):					
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c 68°	attending physi	Med	IF FEMALE:							
Box eath cert	ttend or us	lan/	23b. Was decedent pregnant	i, outcome of pregnan	death 3 Ector	oic pregnancy			23d. Date of defi Month	very Day Year
O :	the a	ysic		regnant at time of dea Inknown	atti 5 Ottie	or (specify)				
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O S	been sig	ete						24a. Was an	24b. Were au	topsy findings available
Re a	cate hes , page 2 a	Completed by Physician/Medi						autopsy	d? death?	completion of cause of
		O O	25. Was case referred to medical			2	6. Pface of Death		No 1 ☐ Yes	140
sicls <	is certific director,	To B	examiner?	1 ☐ Inpatient 2 ☐ E	R/Outpatient 3[	DOA Other:		e 5 Residenc	e 6 Other (Spe	OSPICE
o E	er this		27. Manner of Death 28a. I	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	t 2	8d. Describe how	injury occurred	
ig in	r: Aft	atlo	2 Accident investigation	, , , , , ,	M		s 2 No			
ViS	recto	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At horoulding, etc. (Specify)	me, farm, street, fa	actory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
is o	rrs aft rel DI led in	Cer								
Division of Vita	within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only  (C	o the best of my know the basis of examination manner stated.	vledge, death occu on and/or investig	urred at the time, ation, in my opin	date and place, a ion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the	thin 2 the imple	Med	one) and 29b. Signature and title of certifier	mariner stated.		29c. License n	umber	29d.	. Date signed (Mont	h, Day, Year)
۲	₹ 8		1 Ster MAD			0	7-417	, D	combect	2005
	$\wedge$		30. Name and address of person who completed	cause of death (ftem	23a) (Type, Print)	V	11116	, JA	COLIVORI (	0, 2000
	7		E. TSO MD Riche	11	838 1	V. Eut	aw St	Baltin	ecember ( nore MD	21201
34.2	St	ate	31. Date filed (Month, Day, Year)	2. Prigistrar's Signati	ure	N.				
57 6 12	Regist	rar	DEC 2 2 2005	Balling a	The Const	2.1				

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The don Walker 12/6/05 210pm

			1 - For State Registrar	State of Marylar			of Health of Deatl	h	R	eg. No.	05	1354
	Physici /Medic		1. Decedent's Name (First, Middle, Last Alice E. W	/hite					2. Date of Dea Month	Day	Year 005	3. Time of Death 1915 M
	Examir		4a. Facility Name (If not institution, give	ents Drive		Balt	un, or Location				inty of Death	
N.	Funeral Director		5. Social Security Number  220-20-9/23  Usual Residence of Decedent	7. Age (In yrs. 78	(ast birthday) Yrs.	Months C	Pear If Under	Min.	B. Date of Birth (Month, Day 10 - 28-	(Year)	Cour	place (State or Foreign http)
	Maryland -f show lied at	tor	10a. State 10b. County		ty, Town or Lo						1	0d. Inside City Limits 1 ✓ Yes 2 □ No
	with the	i Director	10e. Street and Number 4225 St. Vincen			10f. Zip Co	215		1	-	of What Cour	ntry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	d by Funerai	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			t of Hispanic C Cuban, Mexic		ify Yes or No- ican, etc.)	14. [	Race - Americ Black, White,	
21215-0	d within 72 h giene. er then "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual C kind of work of DO NOT use i	done during mo retired)	ost of working	9		f Business/In	dustry
Maryland	e should be filed and Mental Hygin is marked other sumatic event,	To Be	James E. WI	nite					Stan		,	
	0 = =		19a. Informant's Name/Relationship (T)  Christine Ba:  20a. Method of Disposition  1878urial 2   Cremation 3   18	rne 5		sition (Name	incent	Da Dr.	Balti te	more,	Md.	21215 own, State
Baltimore,	permit. Pag Department Important: I eny injury c once.		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Lions	K <sub>1</sub>	ng Mem	. Name and A		ality The	2005 Derrick e, Balt	C. Jov	nes Fu	neral Homa P.
54	Physician /Medical Examiner physician up project physician and physician and physician state of the physician physic	cai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consec	quence of):	=sev/	^	ccide	T		6	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed the hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregni 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	Ectopic pregr Other (s <i>peci</i>				23d.	Date of delive Month	ory Day Year
ords, P.	w requires that t been signed by should be detac	2	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying caus	se given in Pari	t 1.	23e. Did tot			ne cause of death?
	(0)	Completed							24a. Was a autops perform	y	b. Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of
Vita	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA	Othor	ce of Death (	Check only on		Other (Specific	
ion of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28	d. Describe ho			<i>/</i>
Division	Oire Dire	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, o	ffice	28	If. Location (St City or Town		ımber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (	29a. Certifier (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	n occurred at t vestigation, in	the time, date a my opinion, de	and place, an	d due to the ca	ause(s) and ate and plac	manner as st	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	My MY			icense number		2	9d. Date sig	ned (Month,	Day, Year) 2005
	B		Rubert KiRo	ompleted cause of death (Iter	n 23a) (Type, 5 Wes	Print) TBe)v	e Jerk 1	Avenve	·Sv.Ke	22 1	Betton	20,2005 are MO21213
	Sta Registi	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	- Art						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Year Month wheeler **Physician** recember 13 0:45 Am 2005 Kenneth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) Examiner Home Saltimore Baltimore NUrsing romivel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1≅M 2□ F 5. Social Security Number 6 Sex **Funeral** Days Hours Months Yrs. Sept 1, 1929 Maryland 217-26-7950 76 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mentel Hygiene. Int: If Item 27 is marked other than "natural; or items 23s or 28s-5 show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Baltimore Funeral Olrector MD Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21234 USA 8710 Emge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 ☐ Yes 2 ∑No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0020 Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 warehouse worker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Wheeler Eva Gossman 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth er Important: if Item 27 is any injury or other training. Eva Lawlor/daughter 509 Brandyvale Way Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street XLO 21201 Baltimore, MD\_ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner use es the bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. funerel diractor, pege 2 should be datached 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? has 2 L No 1 ☐ Yes 2 ☐ No this certificata 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28b. Time of Injury 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After complataly filled in by the funer death. aftar To the Hospital of within 24 hours a To the Funeral D

5 Pending investigation 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifie

30. Name end address of person who completed cause of deeth (Item &3e) (Type, Print) Qinglin GAO, MD Blvd

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature Constant of Western .

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 20,2005 Month **Physician** December 12:02A L. Williams Ralph /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□ F Director 180 22 7222 Warren, Nov 7, 1929 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, Item Madical Examinating must be conflict at 1 ☐ Yes 2☐No Director Maryland Prince George Suitland [ ] 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5005 Bridgeport Drive 20476 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XA Married
3 Widowed 4 Divorced 1.□Yes 2□NoVietnam HYAs, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No à Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Airforce Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Williams Madeline Lingle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Willimas (Wife) 5005 Bridgeport Drive, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1221 MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown certificete hes been signed by irector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Ave. #c 101 Clinton, Md. 20735 Laxmi N. Berwa, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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la la	/Medic Examin		4a. Facility Name (If not institution, give		Atcher	SOH	4b. City	, Town, or	Location of		ecembe		2005 ounty of Death	4:40 A. M	_
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Division of Vital Records,	s effer deatl al Director: ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, stre	et, factor	y, office		281	Location (S City or Tow	treet and N n, State)	umber or Rura	al Route Number,	Ì
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			For State Registrar	State of Maryla	and / Dep	artment of H	ealth and N	dental Hygie	ene 05	358
			Decedent's Name (First, Middle, La	ast)				2. Date of Death		3. Time of Death
	Physicia		JAMES	ALLEN				Month DECEMBER	Day Year 6 2005	3:34 A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or BRANDYWI	Location of Death		4c. County of Deeth	1
	Funeral Director		5. Social Security Number 6. 159-26-4822		rs. last birthday, Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) MARCH 21	(ear) 9. Birth Con 1930 NORT	nplace (State or Foreign untry) 'H , CAROLINA
	aryland show	70	Usual Residence of Decedent           10a. State         10b. County           MD         PRINCE		City, Town or L					10d. Inside City Limits 1 1 Yes 2 □ No
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0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Health and	by	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 X Yes 2 PA 1  If Yes, Give Year or Dates:	rforce	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
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1 1	Funeral Director	. ·	HOLY CROSS  5. Social Security Number  6. Security Number  77 /0 /729  Usual Residence of Decedent	HOSPITAL 7. Age (In yrs. las	st birthday) If Under 1		8. Date of Birth (Month, Day, JAN IC		POMERY  pplace (State or Foreign  untry)  MD.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If term 27 is marked other then "natural; or items 23s or 28e-f show important: If then 27 is marked other then "natural resulting any injury or other treumatic event, the Hudical Examinar massice inclined at once.	al Director	10a. State 10b. County  10c. Street and Number  239 - 16 TH - 5 T	WA	SHINGT			og. Citizen of What Cou	10d. Inside City Limits 1
		Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	. 13. Was Deceder If Yes, specify	it of Hispanic Origin? (S Cuban, Mexican, Puert No Specity:		14. Race - Amer Black, White	LACK.
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		To Be	17. Father's Name (First, Middle, Last)  CONSE Thomas  19a. Informant's Name/Relationship (Ty	pe, Print)		Electronic Street and Number 191	ral Photo Sumbay	Quande Appropriesary	19000000904
			20a. Method of Disposition  1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Plac cerr	ice of Disposition (Name metery, crematory or othe JCOLN MA	EM. 12/	Date 2	SUITELA	rown, State
Balt	permit. Pa Departmen important: eny injury		21. Signature of Funeral Service Licens  22a. Part I. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the death.	3015	Address of Eacility  T. RIHIN  -/2TH S  of dying, such as cardiac	T.NE	WASHOC	+OME - 20017 Approximate Interval Between
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and point to the Funerel Director: After this certificate has been signed by the attending physician and point completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and point point point to the funeral director, page 2 should be detached for use as the burial-transit and point point point to the funeral director, page 2 should be detached for use as the burial-transit.	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	TNSU	FFICIE	NCY		Onset and Death
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1   Live birth 2   Fetal d 4   Pregnant at time of dea 9   Unknown	death 3 Ectopic preg			23d. Date of delive Month	very Day Year
		5	Part II. Other significant conditions co	ntributing to death but not resulti	ting in the underlying cau	se given in Part I,		acco use contribute to	*/
		Be Completed	25. Was case referred to medical			26, Place of Dea	24a. Was an autopsy perform 1 Yes 2	No 1 ☐ Yes	topsy findings available ompletion of cause of
		၉	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Est 28a. Date of Injury (Month, Day Year)	ome 5 Resider	5 Residence 6 Other (Specify)  Describe how injury occurred			
		al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  ysician: To the best of my knowledge, death occurred at the time, date and place			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		Medical	(Check only one)  2 Medical Examination Medica	ner: On the basis of examinatio and manner stated.	on and/or investigation, in	my opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
			30. Name and address of person who co	m - D  propleted cause of death (Item 2	23a) (Type Print)	0060038	Sil Sil	12/02/0 VER SP MD. 20	RING
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 8 2005	MOOLE 1500	Aprile Aprile	- Luci Luci / V / V	N.D.	1000.00	-110

			1 - For State Registrar	State of Ma	aryland / De		tment of H ficate of L		Mental Hy	/gieri Reg. N	UUU.	41360
	Physici /Medi		Decedent's Name (First, Middle, L     Dwayne Vernon A						2. Date of Do Month Decemi	Da	y Ye	
	Examir										c. County of D	
			Southern Maryland Hospital				Months Days Hours Min. (Month,			Prince Georges		
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 12-M 2 F		ge (In yrs. last birthday) 40 Yrs.						9. Birthplace (State or Foreign Country) 965 Washington, DC	
-	D .	4	Usual Residence of Decedent							,		
aryiana z	how	_	10a. State 10b. County		10c. City, Town o	or Locat	ion					10d. Inside City Limits
	a-f-	Director	Maryland Prince Georges Brand				lywine					1 ☐ Yes 2 🛣 No
	11 th	ire	10e. Street and Number				10f. Zip Code 10g			10g. C	itizen of What	Country?
	15 wil	al	7710 Dyson Rd				20613			USA		
		To Be Completed by Funeral	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  II If Yes, Give Year or Dates:	Ever in U.S.		s Decedent of Hi es, specify Cuba Yes 2 No		Specify Yes or No no Rican, etc.)	0-		merican Indian, /hite, etc. Black
	within 72 hours after ene. than "natural", or Ite he Medical Examira		(Specify only highest grade completed) (Giv.			Give kin	dent's Usual Occupation skind of work done during most of working DO NOT use retired)			16b. F	6b. Kind of Business/Industry	
	gien gren gren gren gren gren gren gren gr		12			Ca	terer				Food Se	ervice
	be filed withintal Hyglene. d other than event, the M		17. Father's Name (First, Middle, Las					18. Mother's Na	ime (First, Middle	, Maidei	n Sumame)	
	Venta Venta rrked rric ev		Joseph Francis	Armstrong				Marie	Rustin			
	s 1 and 2 should I f Health and Meni Item 27 Is market other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing A	Address (Street a	nd Number or F	lural Route Numb	er, City	or Town, State	e, Zip Code)
	2 = Z		Marie Rustin /	Mother	771	.0 D	yson Roa	ad Brand	lywine MI	20	613	
ē	of Head		20a. Method of Disposition	7	20b. Place of D cemetery,	ispositi	on (Name of ory or other place	a) l	Date	20c. L	ocation - City	or Town, State
Ĕ	Pages nent of int: If Its iry or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		St. Jose	ph's	Cemetery	Dec	. 14, 2005	Mor	ganza,	MD
ранишо	permit. Pages Department of t Important: If Ite any Injury or or once.		21. Signatore of Funeral Service Licensee  22. Name and Address of Facility  Mattingley-Gardiner Funeral Home, P.A.  P.O. Box 270, Leonardtown, MD 20650									
	Physician		23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Death Death Death Death Death Death Dea									
E	To the Hospitel or Attanding Physician: The law requires thei the death certificele be executed within 24 Hours after death.  To the Funeral Director: After this certificele has been signed by the attending physicien and completely filled in by the funeral director. page 2 should be detached for use as the burial-transit of page 2.	edical Examiner	Due to (or as a consequence of):  Sequencially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									
o ≺	ding I		IF FEMALE:	22a If was outcome	of accompany.							
. DOX	the death c y the attend ached for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year	
Š	s the	y P	Part II. Other significant conditions					n in Part I.	23e. Did t	obacco	use contribute	to the cause of death?
cords,	quire n sig uld b	pe F	ACQUIRED IMI	nuno defi	CIENCY	DE	SEASE		10	Yes 2	□No 3 🗀	Probably 4 Onknown
	s bee	Completed by	CEREBRAL &	DEMA					24a. Was	an	24b. Were	autopsy findings available
ב	he la	Ē							auto	psy prmed?_	prior t death	o completion of cause of
g	in: T	Ö	25. Was case referred to medical	1					1 ☐ Yes	2 1 No	1 U Y	es 2 No
DIVISION OF VIEW	sicia cert irect	00	examiner?	Hospital:	nt 2 ER/Outpa		Othe		ath (Check only o			
	rthis raldi	: To	27. Manner of Death	28a. Date of Injur			3 DOA Oute	4 ∐ Nursing I	Home 5 Reside			oecify)
	ding Afte fune	둳	1 ☑Natural 5 ☐ Pending	(Month, Day	Year) Inju	iry	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred			
	el or Atten s after deat il Director: id in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)				eet, factory, office 28f. Lo		28f. Location (S City or Tox	Location (Street and Number or Rural Route Number, City or Town, State)		
	the Hospit in 24 hour he Funera pletely fills	Medical C	29a. Centifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To t To t Comj	Σ	29b. Signature and title of certifier				29c. License				-	onth, Day, Year)
			DORIE DORIE				D40324 DE		DEC	ECEMBER 12,2005		
			30. Name and address of person who TERRY JODRIE	completed cause of de	eath (Item 23a) (Ty	rpe, Prin	OAD, C	LIGUTOR				26735
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	54				-		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Belton Daisy 6:11 P.M 2 --2005 02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Hospital Center Cheverly
If Under 1 Year | If Under 24 Hrs. Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min 1 ☐ M 2 🔀 F 79 Yrs Director 578-34-5548 1/13/26 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show 1 Yes 2 No Md. Director P.G. Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7014 Fresno Street 20743 Completed by Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes XXNo Black Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) Coflege (1-4or 5+) Beautician Hairstyling yrs. of Health and Mental Hygie litem 27 ie marked other r other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Washington Daisy Gaddis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Henderson, Jr. / Son 7014 Fresno St., Seat Pleasant, Md. nt of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Mt. Olivet Cem. 12/8/05 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. SRAW 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 been signed by the s should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes b lirector, page 2 s autopsy performed? 1 Yes 2 X No 2 No or Attending Physicien: 25. Was case referred to medical examiner?
1 ✓ ¥es 2 □ No 26. Place of Death (Check only one) Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2ER/Outpatient 3 DOA within 24 hours after death.

No the Funerel Director: After this completely filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title-el 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ashou redacu 4410 Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 8 2005

DHMH 17 Rev 1/200

Registrar

ORIGINAL

			For State	State of Ma	ryland /		irtment of H tificate of I		nd Mei		60	05	+1362
			Registrer  1. Decedent's Name (First, Middle, Last	)		001	incate of t	Jean	2.	Date of De			3. Time of Death
	Physici /Medio		HAROLD BROWN		·				Nc	Month <b>Weriber</b>	30, 2	005 Year	21:50 P M
	Examir	er	4a. Facility Name (If not institution, give Southern Maryland				4b. City, Town, or Clinto		Death		4c. Co	unty of Death	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last b	irthday)	If Under 1 Year	If Under 2	4 Hrs. 8.	Date of Bird	th Your	P.G. 9. Birthp	lace (State or Foreign
	Director			ZM 2□F (	32	Yrs.	Months Days	Hours	1	Date of Bird (Month, Da 1/07/	1923	Sout	h"Carolina
	yland yow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					1	0d. Inside City Limits
	e Mar	ctor	MD P.G.		Suit	land				,			Yes 2 No
	with th	Funeral Director	10e. Street and Number 3940 Bexley Place				10f. Zip Code 20746	5			10g. Citizen	of What Coun	itry?
	death me 23	nera	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of H	ispanic Origi	in? (Specify	Yes or No	- 14.	Race - Americ	
920	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nature!; or items 23a or 28s-1 show any injury or other traumatic event, it is Medical Examinar must be codified at ODEs.	Ď	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 4			Yes, specify Cuba	Specify:	Pueno Hic	an, etc.)		Black, White, ecify: Bl	<sub>etc.</sub> ack
2	72 ho	eted	15. Decedent's Edu (Specify only highest grad		166	(Give	lent's Usual Occupa	during most o	of working		16b. Kind	of Business/Inc	dustry
21215-0036	within iene. then	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+	)		00 NOT use retired hef	)			U.S.	Navy	
DQ 2	al Hygie d other went,	BeC	17. Father's Name (First, Middle, Last)								Maiden Sur		
Maryland	d Ment d Ment narke natic	٦ و	Sylvester Brown  19a. Informant's Name/Relationship (7)	una (Deint)	40	h Mailia	g Address (Street			mmond	Cit T	01-1- 7:-	0-4-1
	nd 2 sl lith and 27 ie r r traur		Fannie D. Brown -				Bexley Pl					wn, State, Zip 1746	Code)
ore,	of Her of Her if item or othe		20a, Method of Disposition 1,□Burial 2 □Cremation 3 □F	Removal from State	20b. Place	of Dispo	sition (Name of natory or other place	- 1	Date			ion - City or To	wn, State
altimore,	t. Pag rtment rtent: i		4 Donation 5 Dother (Specify)		Arlin	and the original section is	n Nat'l C						/iryinia
Ba	Depa Impo eny i		21. Signature of Funeral Service Licens	freen	an		. Name and Addres						
ı			23a. Part Enter the disease, or composhock, or heart failure. List only o	lidations that caused to no cause on each line	he death. Do	not ente	er the mode of dyin	g, such as ca	ardiac or re	spiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	epsis	a of):							
	Examiner		Sequentially list conditions	h	aprisequence	<b>9</b> 01).							
	ed ist	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):							
Ć.	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence	of):							
8760,	icate be executed physician and s the burial-transit	dical		d									
ဖ	leath certific ettending p I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy						23d	. Date of delive	ny
S. Box	Attending Physician: The law requires that the death certif refeath. rector: After this certificete has been signed by the ettending by the funeral director, pege 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			Ectopic pregnancy Other (specify)				250.		Day Year
P.O.	uires that the de signed by the e Id be detached f	Phy	9 ☐ Unknown  Part II. Other significant conditions co	ntributing to death but	not resulting	in the ur	nderlying cause give	en in Part I.		23e. Did to	obacco use	contribute to th	e cause of death?
rds	w requires been sign should be	ed by	Pseudo nembrinos	colehis	7	/ /				1 🗆 🗅	Yes 2 JA	б 3∏Prob	ably 4 □Unknown
0 0 0	lawre as bee	Completed	aute renal fai	burewith	hype,	rkali	min			24a. Was		prior to cor	osy findings available inpletion of cause of
<u>a</u>	The icete h				V					1 Yes	rmed? 2 ☑ No	death? 1 ☐ Yes	4
Ĭ	ysiclar is certification	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ER/C	utpatien	t 3□ DOA Othe	00		heck only o		Other (Specify	····
Division of Vital Records,	ding Physician: The law h. After this certificate has funeral director, pege 2		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injun Work	rat c?	28d		now injury oc		<u></u>
isio	death death ctor: A y the fi	ficati	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	v - At home, t	arm. stre		Yes 2 N		Location (5	Street and N	umber or Rura	l Route Number.
2	tel or / rs after el Dire ed in b	Certification;	4 Homicide	building, etc.	(Specify)					City or Tov			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai	29a. Certifier Check only one) Certifying Phy 2 Medical Exemi	sician: To the best of iner: On the basis of e and manner state	xamination a	ge, death nd/or inv	occurred at the timestigation, in my op	ne, date and pinion, death	place, and occurred a	due to the at the time,	cause(s) and date and pla	d manner as st ce, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c. License				29d. Date si	gned (Month, I	Day, Year)
<b>.</b>	( ) lu		> Nam-	N			200	55120	)		Dec	1 2005	
2	13) IV	9	30. Name and address of person who a Richard Palmer M	ompleted cause of deal	inhem 23a	Avec	Print) we SE Sm	h310	Wa	hong to	in AC	20032	
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 8 2005	Registrar	's Signature	do	Print) une SE Sm						

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			State of Maryla State of Maryla State of Maryla State of Maryla General Registrar	ind/Dep 2,02/4	artment of H	ealth and M Death	lental Hyg R	giene 1.005	1:1363
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	_	3. Time of Death
	/Medic		LINDA SUE LOTZ-	В	ROWN		DEC	5 2005	0658 M
	Examir	er	4a. Facility Name (If not institution, give street and number)  MEMORIAL HOSPITAL		4b. City, Town, or EAST			4c. County of Dear	
	Funeral		5. Social Security Number 6. Sex 7. Age (In ye	rs. last birthday,	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
- 1	Director		213-42-0962 <sup>1□M 2</sup> 61	Yrs.	Months Days	Hours Min.	(Month, Day 1 - 25 - 1		isfield Md
	and		Usual Residence of Decedent           10a, State         10b, County         10c.	City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	to	Md Talbot Bo	zman					1 ☐ Yes 2 X No
	h with the Maryland 23a or 28a-f show st.be notified at	Funeral Director	10e. Street and Number 8120 Ruby Harrison Road		10f. Zip Code 2161	2	1	10g. Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event. The Medical Examinat roust by notified at once.	b	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 【XNo	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: WI	e, etc.
Maryland 21215-0036	within 72 ho ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12 years 5	16a. Dece (Give life. Teac	edent's Usual Occupa e kind of work done d DO NOT use retired)	ition luring most of worki )	ing	16b. Kind of Business	ndustry ry School
land 2	uld be filed fental Hygi rked other tic event.	To Be C	17. Father's Name (First, Middle, Last) Granville Evans			18. Mother's Name	G (First, Middle, agnes S	,	
	alth and No. 27 Is mail		19a. Informant's Name/Relationship (Type, Print) Ralph E. Brown (husband)		-			r, City or Town, State, A Bozman, Mo	
Baltimore,	Pages 1 and the period of Heining In Item		1 Murial 2 Compation 3 Permayal from State	o. Place of Disp cemetery, cre road C	osition (Name of ematory or other place Creek	12-1	2-2005	20c. Location - City or Bozman	
Balti	permit. Departm Importa any Inju		T. Carrell Hurber					uneral Ho	
	Physician		23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	1		90% astalogok OldVASCUL			Approximate 3 Interval Between Onset and Death
	/Medical Examiner		Due to (or as a cons	sequence of):	IIC GIF	V TOVAD CUC	MC VIV	CAJE	
	betra:	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):					
KC 58760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last  Due to (or as a cons	equence of):					
		Medi	IF FEMALE:						
ik Mail	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
Mi Chro	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not of		underlying cause give	n in Part I.	23e. Did to	bacco use contribute to es 2 No 3 □ Pr	the cause of death?
Sich al Added Mic	<b>hysician</b> : The law r his certificate has be I director, page 2 sh	Completed					24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of 2 \( \sum \text{No} \)
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?		Otho	26. Place of Death			
# 5	Physic rthis ral dir	- To	1 ☐ Yes 2No 1 ☐ Inpatient 2  27. Manner of Death 28a. Date of Injury	28b. Time of		4   Industry Ho		ence 6 Other (Spe	cify)
100	nding Ph ith: : After th e funeral	atlon	Natural 5 ☐ Pending (Month, Day Year, 2 ☐ Accident investigation	) Injury	Work	? (es 2 🗆 No		,,	
Divis	al or Atters s after dea if Director id in by the	Sertifica	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or Run, State)	iral Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the best of my leading to the basis of examiner and manner stated.	knowledge, dea ination and/or ii	th occurred at the tim nvestigation, in my op	e, date and place, sinion, death occurr	and due to the co	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To the To the County	2	29b. Signature and title of certific American, 1	0.0.	29c. License	7211		29d. Date signed (Mont	
	10)		30. Name and address of person who impleted cause of death (I)	Item 23a) (Type		UMBIA, A	10 21	045	-,
	Sta Registi		31. Date filed (Maptin De Cy, Oead) 2005 32 Registrar's Sig	gnature	fool				

			State of Maryland / Department of Health and N  1- State Registrer Certificate of Death		ene 005	41364
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia	an	Lemuel Homer Benton Jr.	Nov. 2	Day Year 2005	12:55a <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. Cily, Town, or Location of Death	NOV. Z	4c. County of Dea	
	Examin	er	309 South Church Street Sudlersville		Queen i	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
п	Funeral		213-09-8098 X M 2 F 89 Yrs. Months Days Hours Min.	(Month, Day, Y	(ear) Co	ountry)
	Director	-	Usual Residence of Decedent	04/27/	1916 P	4
	land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary f ah	0	MD Queen Anne's Sudlersville			1X∑Yes 2 No
	the 1	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	ountry?
	with a or	۵			JSA	•
	eath	eral	307 23431 3144 2144		14. Race - Ame	erican Indian.
	iurs after death with the Marylan al', or items 23a or 28a-f ahow Examitter must be notifited at	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
36	rs af	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: W	nite
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-1 ahow Jeal Ezareller nust be notified at		15 Decedent's Education 16a Decedent's Usual Occupation	16	Sb. Kind of Business	Industry
15	C	olet	(Specify only highest grade completed) (Give kind of work done during most of work	king		ŕ
21215-0036	filed within 72 ho Hygiene. Ahar than "natur int, Ing Vices	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  1 1 Maintenance Worker	c	Retail	
	Hyg tha int,	a l	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Maryland	Ments Ments arkad	To B	Bemaer nemer beneen br	Rebecca		
Jar	2 sho and is ma rauma		19a. Informant's Name/Relationship (Type, Print)  Jovce Benton/Daughter  19b. Mailing Address (Street and Number or Rui 211 Manor Ave. Che			
	os 1 and of Health itam 27		Joyce Benton/Daughter 211 Manor Ave. Che 20a. Method of Disposition (Name of		c. Location - City or	
0	00 = =		1 Service 2 Cremation 3 Removal from State cemetery, crematory or other place)			
Ë						ville, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Fellows, Helfer 370 W Cypress	nbein & St Milli	Newnam I	Funeral Hon D 21651
			23a fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	andre		Onset and Death
	/Medical		resulting in death)  Due to (or a consequence of):			2-3112
п	Examiner		Hupertension			5-10415
		Je.	Sequentially list conditions, in any, backing to him solate cause. Enter Undertying Cause (Disease or injury			
	outed ansil	Examiner	Cause (Disease or injury that initiated events c.			the state of the s
oʻ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	te be ysicia ne bu	cal	d			
9	tifical g ph	edi				11024-1-102
Вох	death certifica attending ph d for use as tl	N .	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	livery
m	death e atte d for	Physician/Medical	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
0	that the de ed by the detached	hys	9 ☐ Unknown			
0	res that signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds	quire n sig ald bu			1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
00	w requir	lete		24a. Was an	24b. Were a	utopsy findings available
Records,	ne lav s has ge 2	Completed		autopsy performe	ed? death?	completion of cause of
a	ician: Th certificate rector, pag		25. Was case referred to medical 26. Place of Dea	<del></del>	∃No 1 □ Yes	2 1 No
Vital	ysician: The is certificate hidirector, page	Be	examiner?	th (Check only one)		-14.1
of	두 두 등	2	To the state of th	28d. Describe how	ce 6 Other (Spe	icity)
u	Attanding I r death. actor: After by the funer	lon	Natural 5 Pending (Month, Day Year) Injury Work?		. ,	
S	r Attandii er death. ractor: Al by the fu	ica	3 Suicide 6 Could not be	28f. Location (Stre	et and Number or R	ural Route Number.
Division	or A after Dirac in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,		
	pital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cau	use(s) and manner a	s stated.
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	edical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, dat	e and place, and du	to the cause(s)
	4549	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mon	h, Day, Year)
	o to to			1 1	1290	
	To t To t		11/1/1/137	/	1 1.	<i>U</i> 5
1 10	y Tor		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/	1 (	J5
V	2) S		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		le MD 21	617
V	2) 5	ate			le MD 21	617
	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Semra Sahinci, M.D. 420 Pennsylvania Ave. Ce		le MD 21	617

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2325 Joan Bassett Marie 12 OF /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lll Linda Dr., Apt. Cl Fruitland Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🛛 F 031-12-4415 Yrs 81 Director 9/2/1924 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar man to contact. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 □ No Directo Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? lll Linda Drive, Apt. Cl 21826 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Bastimore, Maryland 21215-00201 ☐ Yes 2 No Specify: Specify: white δ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poultry Worker Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur R. Bassett Sarah Foster ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine M. Mumford/daughter 28420 Delaware Ave., Millsboro, DE 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 12/2/05 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
HOTIOWAY Funeral Home Professional Association 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Physician Immediate Cause (Final disease or condition resulting in death) /Medical ASCVD Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Yes 2 No 3□ DOA this : After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D completely filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 4105 45049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salis buy 21801 Chris Swyder 100 E Carroll 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 7 Registrar

			1- For State of Maryland / D		artment of tificate o		and M		iene 05		1366
	Physicia	an	1. Decedent's Name (First, Middle, Last)					<ol><li>Date of Dea Month</li></ol>		Year	3. Time of Death
	/Medic		Dorothy V. Bailey					Nov.	27, 200		12:00 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		•	n, or Location o	of Death		4c. County o		
			707 Douglas Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday)	If Under 1 Year	ridge ar   fUnder:	24 Hrs.	8. Date of Birth	Dore		er place (State or Foreign
М	Funeral Director		4 TH 4 OFF	Yrs.	Months Day		Min.	(Month, Day June 2	Year)	Cou	yland
	ט		Usual Residence of Decedent					oune 2	1,2001		
	aryiar show	ڀ	10a. State 10b. County 10c. City, Town	ı or Lo	cation						10d. Inside City Limits 1 No 2 □ No
	8e-f	Director	Maryland Dorchester Cambr	ids					- 011		
	with t		10e. Street and Number		10f. Zip Code				0g. Citizen of W	nat Cou	ntry?
	ns 23	Funeral	707 Douglas Street  11. Marital Status 12. Was Decedent Ever in U.S.	13 \		513 of Hispanic Ori	nin? (Sp	cify Yes or No-	USA 14. Bace	- Ameri	can Indian.
	r Iten	Fun	Armed Forces?	1	f Yes, specify C	uban, Mexican	, Puerto	Rican, etc.)		, White,	
936	urs a	by	1 Never Married 2 Married 1 Ses 2 No If Yes 2 No If Yes, Give Year or Dates:	•	1□Yes 2001	No Specify:			Specify:		lack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show tas Madical Exiz viller in ust be multified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	(Give	ient's Usual Occ kind of work do	ne durina mosi	t of work	па	16b. Kind of Bus	siness/In	dustry
7	ithin ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use ret	rired)		9			
7	lled w tygien ther ti	Ŝ	12 17. Father's Name (First, Middle, Last)	Unl	known	19 Motho	r'e Name	/First Middle	Unknov Maiden Sumame		
anc	tbe find the orter of orter the orte	Be						Gaine		<del>)</del> /	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, it is Model Exacilities as any injury or other traumatic event, it is Model Exacilities as any injury or other traumatic event, it is Model Exacilities as any injury or other traumatic event, it is Model Exacilities as any injury or other traumatic event, it is Model Exacilities as any injury or other traumatic event, it is Model Exacilities as a second event ev	P		. Mailir	na Address (Stre	Mar eet and Numbe	J		, City or Town, S	State. Ziu	Code)
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Ē,	is 1 and 2 of Health a item 27 Is other trau		20a. Method of Disposition 20b. Place of	Dispo	sition (Name of natory or other p	1			20c. Location - (	City or To	own, State
Ë	Page nent o nt: If		1 Burial 2 Cremation 3 Removal from State			- 1	2-03	-2005	neensto	m. I	Maryland
altimore,	permit. Departmingorta		21. Signalure I Funeral Service Licensee		. Name and Add	dress of Facilit	у		,		
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9	tificat ig phy as the	Physician/Medical					-				
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B	n requires that the death been signed by the atte should be detached for	sicia	in the past 12 months?  1   Yes   2   No   9   Unknown		Other (specify)				Mon	th	Day Year
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orc	requi	Completed by	Light to the strong of the	,	100001	17(0 7					
3ec	B 8 6	uple	disease, hypertension, hyperty	1616	derive,	COCAI	ne	24a. Was a autops perfori	y pr	ere auto for to co eath?	opsy findings available empletion of cause of
alF			dependence congestive thear	t	tailur	~		1 Tes	208 No 11	Yes	2 No
Σ	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Out		4 2C DO4 (	Other		(Check only on	ence 6 ⊡Othe	(0	4.)
of	Phy r this aral d	To :	27. Manner of Death 28a. Date of Injury 28b. T	Time of	28c. Ir	njury at	-		ow injury occurre	. ,	Ty)
ion	Attending r death. ector: After y the fune	atlor	1 □ Natural 5 □ Pending (Month, Day Year) In 2 □ Accident investigation	njury		Monk? I∐Yes 2.∐I	No				
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Ö	tal or A s after al Direc ed in by	Certification:	Outlaing, St. (Specify)					City of Your	, State)		
	t hour uner uner	edical	29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and	death	occurred at the	e time, date an	d place, th occurr	and due to the c	ause(s) and man	ner as s	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medi	one) and manner stated.			ense number					
	To COr	-	29b. Signature and title of certifier				0		9d. Date signed	(MOTHER)	1 0
	F .		27 alun, Mo		1	05993	>1		Decem	per	1,2005
			30. Name and address of person who completed cause of death (Item 23a) (	Vir	5 he	et C	amb	ondge,	MD 2	2161	3
	Sta Registi		31. Date liled (Month, Day, Year)  DEC 1 2 2005  32. Registrar's Signature	1	A All						

			For State Registrar	State of M	larylan		irtment of		and Mental	Hygier	711115	41367
	Physici	an	1. Decedent's Name (First, Middle, La	•	KS			1	Mont	of Death	Day Year	3. Time of Death 1:39 PM
L.	/Medic Examin		4a. Facility Name (If not institution, giv		)		4b. City, Town,		of Death		03 2.00 4c. County of Dea N/A	
E	Funeral Director		5. Social Security Number 217-62-7915	ex 7. A □ M 2√2 F	ge (In yrs.	last birthday) 52 Yrs.	If Under 1 Yea Months Day	r If Under	24 Hrs. 8 Date	th, Day, Yea	9. Bir 2953 Ma	thplace (State or Foreign puntry) ryland
	be liked within 72 hours after death with the Maryland nist Hygiane. de ther than "natural", or lieme 23e or 28e-1 show event, the Macical Examicer must be notified at	Director	Usual Residence of Decedent  10a. State  10b. County  1aryland Anne A  10e. Street and Number	rundel		y, Town or Lo		_	44.	100	Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
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030	ours after d	by Funeral	1 Never Married  Married 3 Widowed 4 Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	? [No	į t	Yes, specify Cu	ıban, Mexicar	n, Puerto Rican, et	c.)	Black, Whi	te, etc.
Baltimore, Maryland 21215-0036	within 72 ine. Ihan "nai Iu Madic	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give life. L	lent's Usual Occ kind of work don OO NOT use retii	e during mos red)	•		Kind of Business	,
and z	2 should be filed value of and Mental Hygia Is marked other the teumatic event, II.	To Be Co	11th  17. Father's Name (First, Middle, Last, John F. Howard	0				18. Mothe	ie Pool	liddle, Maid		
Mary	5 A 3 G	F	19a. Informant's Name/Relationship ( James L. Brook		ıd)		-		er or Rural Route A			
imore,	Ly and Pa		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		1 c	emetery, cren	sition (Name of natory or other p d Vete:	ran	Date 12-9-05		Location - City or DWnsvil	
Pair	permit. Dapartr Import. any Inj.		21. Signature of Funeral Service Licer	e moo48		8	21 Wes	se & : t St.	Sons Mo: Annapo:	lis,	y, P.A Md. 21	401
<i>†</i>	Physician /Medical		23a. Part1. Enter/he disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	AS <sup>-</sup>	h. Do not ent	er the mode of d	ying, such as	ST C	ory arrest,		Approximate Interval Between Onset and Death I YEAR
	death certificate be executed to the state of the state o	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a conseq	uence of):	OCAR	DIAL	INFA	RCT	101	
.O. BOX 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	Ectopic pregnar Other (specify)	ncy			23d. Date of de Month	livery Day Year
ras, r	sign d be	by	Part II. Other significant conditions of	contributing to death	but not res	ulting in the ur	nderlying cause (	given in Part I	. 23e.		<b>\</b>	o the cause of death?
I Heco	The law ate has b page 2 s	Completed							24a.	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Y VITA	Physicien: The this certificate had director, page	To Be (	25. Was case referred to medical examiner?  1  Yes  2 No	Hospital:		ER/Outpatien	3 DOA	other: 4 □ Nu	of Death (Checkursing Home 5		6 □Other (Spe	cify)
Division of Vital Records,	ding f	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  27. Manner of Death 5 Pending investigation investigation of betermined	e One Place of It		28b. Time of Injury	M 1	□Yes 2□	No		ijury occurred and Number or R	ural Route Number.
5	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	al Certi	29a. Certifier Certifying Ph	building, e	t of my kno	y) wledge, death	occurred at the	time, date ar	d place, and due t	or Town, Sta	(s) and manner a	s stated.
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 ☐ Medical Example)  29b. Signature and title of certifier	niner: On the basis and manner s	of examina tated.	tion and/or inv		opinion, dea	Ih occurred at the		and place, and due  Date signed (Moni	
)	r s r ŏ		) Sahil	5000	し,	MD		520	101	DE	CEMBER	03,2005
			30. Name and address of person who SAHIL SOOD		-			57.	BALTI	MOR	RE, MD	21225
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 7 20	32. Regis	trar's Signa	iture	ork	,			, -	

		1~ For State Registrar	State of Marylan	d / Depa		ealth and I	Mental Hyg	•	5 41368
Physici /Medic		1. Decedent's Name (First, Middle, Las Richard Marc Bel					2. Date of Deat Month December	h Day	3. Time of Death 2005 4:00 P
Examin		4a. Facility Name (If not institution, give 500 Palisades Blv 5. Social Security Number 6. S	d.	ast birthday)	4b. City, Town, or Crownsv				Arunde1
Funeral Director		213-48-0439 1 Usual Residence of Decedent	<b>⊠</b> M 2□F 56	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 9,	1949	Birthplace (State or Foreig Country)     Mary land
he Marylar 28a-1 ehow ciffic 1 et	Director	Maryland Anne Ar		y, Town or Lo	.11e			0- 0	10d. Inside City Limit
with t	i Dir	10e. Street and Number 500 Palisades Bl	vđ		10f. Zip Code 21032		1	Og. Citizen of V United	and the same of th
2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. I see that 1 see 1 see or 28e-1 show is marked other than "naturel", or item 23e or 28e-1 show aumatic event, it a Medical Erapia at missice or cities at	by Funeral	11. Marital Status  1 Never Married 252 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)	14. Race	e - American Indian, k, White, etc.
ithin 72 hours ie. ien "neture Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wor	king	16b. Kind of Bu	siness/industry
id be tiled w ental Hygien ked other th ic event, the	To Be Cor	17. Father's Name (First, Middle, Last) Sylvin Belkov	4	So	ftware co	18. Mother's Nam	ne (First, Middle, M	Comput	
permit. Pages 1 and 2 should be Deperment of Heelth and Menta Important: If Item 27 is marked eny Injury or other traumatic av <u>once</u> .	_	19a. Informant's Name/Relationship (Cynthia Belkov/ w			ng Address (Street a				
Pages 1 e nent of He ant: If Item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	emetery, crer	sition (Name of natory or other place Cremator	1	Date :	20c. Location · Baltimo	City or Town, State
Department of the post of the		21. Signature of Funeral Service Licer	Comarda						neral Home, In olis, MD 2140
and certificate be executed  why  and executed  why  and  or use as the buriat-transit  for use as the buriat-transit	cal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of the consequence o	uence of):	er the mode of dying		MelW	SSI,	Approximate Interval Between Onset and Death
or death.  •ctor: After this certificete hes been signed by the ettending phy by the funeral director, pege 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day Year
been signed by	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.			ibute to the cause of death?  3 Probably 4 Onknow
ficete hes bee r, pege 2 sho	e Completed	25. Was case referred to medical						ned? d	Vere autopsy findings availabrior to completion of cause of leath?  ☐ Yes 2☐ No
filer death.  Director: After this certificate hes in by the funeral director, pege 2.	ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing H	th (Check only one Reside 28d. Describe ho	nce 6 Othe	1-1-77
47.5	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (St. City or Town		er or Rural Route Number,
within 24 hours after	Medical (	one) 2 Medical Exam	ysician: To the best of my kno- niner: On the basis of examinal and manner stated.	wledge, death	vestigation, in my op	nion, death occu	rred at the time, da	ate and place, a	and due to the cause(s)
To T	2	29b. Signature and title of certifier  Muchael  J	Hertan	0	29c. License	number 2143	8	od. Date signed Dece	(Month, Day, Year)
		30. Name and address of person wide  MICHAEL (C)  31. Date filed (Mostly Doy, Kost)	124 m Ar	ff P	Print) P ENSE	High	ing Aa	NAPOL	mher, 05, 201 S) MD214018
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	& A	reile				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefje [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Howard Royal Busby December 8:15 P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 4, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 ☐ F Yrs. 367-24-7416 79 MICHIGAN Director Usual Residence of Decedent 10c. City, Town or Location Hygiene. other then "neturel", or Items 23e or 28e-f ehow rent, the Madical Examinat must be notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Breezy Creek Court 21811 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give WW I I Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mining Engineer and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Busby Helen Bohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Michael H. Busby (Son) 183 Bay Ave., Huntington Bay, New York 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Importent; If eny injury or once. Cape Henlopen Crem. 12-8-2005 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signatura of Fun Service Licensee 108 William St., Berlin, Md. 21811 ulal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause/gn each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metest, his **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 68760 Physician/Medical Вох IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes a Hospital or Attending Physician: After this certification, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification; 28d. Describe how injury occurred Division 5 Pending investigation 1 Matural 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. degistrar's Signature State 9 2005

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State

Registrar

DEC 0 7 2005

3. Time of Death

1835p

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Yes 2 No

2005

Black, White, etc

Month

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

20

3 Probably

Year

XXUnknown

Division of Vital Records, P.O. Box 68760, certificete director, this funeral After the Hospital or Attending death. 24 hours after deat • Funeral Director: ₽ 1 within To the

P

1 ☐ Yes 2 🛣 No

5 Pending investigation

27. Manner of Death

1 Natural

Certification: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Nem 23a) (1998, Film)
OPHNELL CUMBERBATCH 3001 HOSPITAL DRIVE CHEVERLY, MD 20785 and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

2X ER/Outpatient

28b. Time of Injury

3 DOA

28c. Injury at Work?

1 Yes 2 No

			For State Registrar	State o	f Marylan		artment of H tificate of L			PP() ()	5 4	1372
	Physici	an	1. Decedent's Name (First, Middle, La						Date of Death     Month	Day	Year	3. Time of Death
	/Medic		Mary Elizab		imes		Cox		December 5	,		10:20 P M
	Examin	er	4a. Fecility Name (If not institution, giv Ft. Washington Hosp		nber)			Location of Death		4c. County		•
	Funeral		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	Ft. Washi	If Under 24 Hrs.	8. Date of Birth	Prince	9. Birthpla	ace (State or Foreign
	Director		577-34-5973	□M 2√√F	80	Yrs.	Months Days	Hours Min.	(Month, Day, Y April 10, 1	(9ar) 1925	Mary	(y)
	p >		Usuel Residence of Decedent  10a. State 10b. County		100 Cit	ty, Town or Lo						
	sho	'n									10	d. Inside City Limits 1√√Yes 2 □ No
	the N	Director	D.C. N/A		Wa	ashingto	10f. Zip Code		100	. Citizen of W	hat Count	
	With 30 or		12 8th Street N.E.				2000	2			SA	.,,.
	death ms 2;	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race	- America	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23e or 28e-f show sumatic event. It a Medical Evant actional be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	24∑X No ⁄8		f Yes, specify Cuba 1 ☐ Yes 2☑XNo	Specify:	Rican, etc.)	Specify:	k, White, e Whit	
Q 2	72 ho natur lical	sted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occupa	ation	16	b. Kind of Bus	siness/Indu	ustry
2	ithin 76.	Completed by	Elementary/Secondary (0-12)	College (1	-4or 5+)	iife	DO NOT use retired, Secretary	)		rivate ]	Industr	rv
2	fled w hygier her th	S	11. Father's Name (First, Middle, Last	1			- Decrease y	19. Mother's Name	(First, Middle, Ma			
and	0 =	) Be	Russell Eugene Grin					Mary Hill		iden Sumame	•/	
2	should nd Me mark	10	19a. Informant's Name/Relationship (			19b. Mailir	ng Address (Street a			City or Town, S	State, Zip (	Code)
	alth al		Mary E. Cox, Jr Daught	er		12.8	h Street N.	E. Washing	eton, D.C.	20002	)	
altimore,	as 1 a of He of He itam		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		oate D.C.	c. Location - 0		m, State
Ĕ	Page ment ant: fi	- 1	1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specif		St.		Church Cen			emple Hi	11s, N	Maryland
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic events.		21. Signatur of Funeral Service Licer	nsee	\		Name and Addres 2.60 Oxon Hil				al Hon 20745	
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that c	aused the deat	h. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arrest	ι,		Approximate Interval Between
£	Pnysician		Immediate Cause (Final disease or condition		Aute	Myo	cardial	Infanct	Zon			Onset and Death
	/Medical		resulting in death)	Due to	or as a conseq	12						
	Examiner		Sequentially list conditions,	b								
	led Isit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D49 10 1	or as a sunseq	dence ory.						
	axecu al-tra	Examin	that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of):						
8760,	icate be executed physician and the burial-transit	dicai		_ d								
9	rtificat ng phy as th	Medi	IE EENANI E.									
. Box	es that the death certifi igned by the attending be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna irth 2 Feta ant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery	/ Day Year
o.	t the de	hysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno		164(II 3)	Totaler (specify)					
ď.	ss than gned I	by P	Part II. Other significant conditions of	_	eath but not res	uiting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contri	bute to the	cause of death?
ğ	w require been signatured should b		Mzhimers Di	seese					1 🗆 Yes	2.☑No	3 Probai	bly 4 □Unknown
Division of Vital Records,	e la has	Completed							24a. Was an autopsy performe	pr de	for to come	sy findings available pletion of cause of
Ta Ta	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical					26. Place of Death		No 1	□Yes 🥨	<b>№</b> No
_	ysician: iis certific director,	To B	examiner? 1 □ Yes 2□ No	Hospital:	npatient 2 🗆	ER/Outpatier	t 3 DOA Othe	r: 4 ☐ Nursing Hor	me 5 Residenc	æ 6 □Othe	r (Specify)	
0	ding Ph h. After th funeral		27. Manuar of Death 1 Natural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time of Injury	Work		28d. Describe how	injury occurre	đ	
<u>S</u>	ttandi Jeath. tor: A	cati	Accident investigation  3 Suicide 6 Could not b		of Injury At h			′es 2 □No	204 Lanatian (Ctana	nd and Alverta	O	Dougla Alizandra a
$\overline{\underline{N}}$	at or At after of Direct of in by	Certification:	4 Homicide determined	buildi	ng, etc. (Specif	y)	eet, factory, office		28f. Location (Stree City or Town, S		r or Hurai i	Houte Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: Atter this certifica completely filled in by the funeral director, to	edical C	29a. Certifier Check only one) Certifying Ph	niner: On the ba	best of my kno asis of examina ner stated.	owledge, death	occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and man and place, ar	ner as star	ted. he cause(s)
	To the To the To the To the To the	Me	29b. Signature and his of certifier				29c. License		29d	. Date signed	(Month, D	ay, Year)
	. 20		Klahn			mo	D005	55120	6	ree 6	200	o o
_	(5)		39. Name and address of person who Richard Palmer in	completed caus	se of death (Item	^	Print)	inite 310	Washing	lon De	200	32
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7 2005	<b>2</b> 2. R	egistrar's Signa	ature	K)		Ú			

Amend item#20b, perfn, G850, 12/22/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician November 23, 2005 Marion A. Councell 06:45 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing & Rehabilitation Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. | Months | Days | Hours | Min. | September 21, 19 | 8 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8 Country) MD **Funeral** 1⋤M 2□F Months 212-16-7904 87 Yrs Director Usual Residence of Decedent death with the Maryland works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar rust be notified at MD Queen Anne's Chestertown **Funeral Director** 1 TYes 25 No 28a-f 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 108 Holly Court 21620 USA Items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status iii. Pages 1 and 2 should be filed within 72 hours after of entment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or item 1 ☐ Never Married 2 ☑ Married XYes 2 □ No 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peter Paul Councell Florence Cannon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Councell/wife 108 Holly Court, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Memorial Park
11/26/2005 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ urial 2 Cremation 3 Removal from State injury or Easton, MD `4 ☐ Donation 5 ☐ Other (Specify) permit.
Depertra
Imports
any inju 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road, Chesterown, MD 21620 Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTUS PULMONARY DISBASE Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ivision of Vital Records, P.O. Box 68760, attending physician IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 Tes 2 No 3 Probably 4 2 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2. No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier 15% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057509 face 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 WASHINGTON AND CHESTERTOWN MO MO 21630 31. Date filed (Month, Day, Year) NOV 2 3 2005 Registrar's Signature State

Registrar

		•	For State Registrar		State	of Mar	ryland		artment of			Menta		iene	05	1	1374
		.90	Decedent's Name (Fig. 1)	irst, Middle, Las	st)								te of Deat	h			. Time of Death
	Physici		Markel D.	Clay									ember	Day 07	, 2005		6:30 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not	t institution, give	e street and n	um <i>ber</i> )			4b. City, Town	or Loca	tion of Deat		000		County of Dea		
			VA MARYLANI	D HEALT	HCARE :	SYSTE	EΜ		PERRY	POI	$\mathbf{NT}$				CEC	CIL	
	Funeral		<ol><li>Social Security Numb</li></ol>	per 6. S			(In yrs. las		If Under 1 Yea Months Day		nder 24 Hrs urs Min.	8. Da	te of Birth onth, Day,	Year)	9. Bi	rthplace	(State or Foreign
	Director		189-09-4947	/	A M SOF		07	Yrs.					. 4,1		Pen	nsy	Lvania
	land		Usual Residence of Dec 10a. State 10t	b. County		1	10c. City,	Town or Lo	cation							10d.	Inside City Limits
	Mary faho	ţō	Maryland W	icomico	•	1	Pitts	ville	<u> </u>								1∭Yes 2☐No
	the 728e	rec	10e. Street and Number						10f. Zip Code				1	0g. Citiz	en of What C	ountry?	
	38.0	Funeral Directo	35190 Old	Ocean C	ity Ro	ad			2185	0			Ur	nite	d Stat	es	
	deat	ner	11. Marital Status		12. Was De Armed F	cedent Ev	er in U.S.	13.	Was Decedent of f Yes, specify Cu	Hispani	ic Origin? (S	pecify Yo	es or No-	1	4. Race - Am Black, Wh		ndian,
9	or ite		1 Never Married		1 VYes	2 □ No	6/04, 2/23,	/41	1 □ Yes 2 1 N		ecify:	io modin,	010.7		SpecifWhi	,	
003	ural',	d by	3 X Widowed 4 □			Dates: 1											
5	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23s or 28e-f ahow wit, the Micdical Examiner must be mailified at	Completed	15. (Specify o	Decedent's Ed only highest gra	ducation ide completed	f)		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during	most of wo	rking		16b. Kin	d of Busines	s/Indust	ry
12	withir ene. then	щć	Elementary/Secondar	ry (0-12)	College	(1-4or 5+)	)		Litary	00)			τ	J.S.	Army		
9	filed Hygi other ent, I	a l	17. Father's Name (Firs.	st, Middle, Last)						18.	Mother's Na	ne (First,	Middle, A	Maiden S	Sumame)		
an	id be lental ked o ic eve	To B	Clarence 1	M. Clay	7					Ne	ellie :	M. L	udt				
D.	should ind Men a marke umatic		19a. Informant's Name/	/Relationship (	Type, Print)			19b. Mailir	ng Address (Stre	et and N	umber or Ru	ıral Rout	e Number,	City or	Town, State,	Zip Cod	de)
ظ∑	and 2 ealth a n 27 le		Pamela Kin	namon/d	laughte	r		35190	01d Oc	ean	City	Rd.,	Pitt	svi	11e,Ma	ry1a	and 2185
Clay, Markel D.  Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, the Madical Examinar must be notified at any injury or other traumatic.		20a. Method of Disposit 1 🕅 Burial 2 □ Cr		Demoval from	n State	cen	netery, crer	sition (Name of natory or other p	lace)	Dece	Date	9. 1	20c. Loc	ation - City o Holly	Town,	State
Mai	Pages nent of I ant: If its ury or o		` 4 ☐Donation 5 ☐	Other (Specific	8 /2	II State	Mt. Ceme	Holl:	y Spring	S	200	5		Penn	sylvan		riigo,
'alt	permit. Departr Imports any inju		21. Signature of Punera	al Service Licer	1500				. Name and Add								
lay	80 = 90		1/hbrell	0.0	re										st,Mar	Ť	nd 21901
O			23a. Part1. Enter the di shock, or heart fai	lisease, or com ilure. List only	plications that one cause on	caused the	he death.	Do not ent	er the mode of d	ying, suc	ch as cardia	or respi	ratory arre	est,		Inte	proximate erval Between set and Death
	Physician		Immediate Cause (Fina disease or condition	al	a. Acu	te My	yocar	dial	Infarct:	ion							known
~	/Medical Examiner		resulting in death)		Due to	o (or as a	conseque	nce of):									
		_	Sequentially list condition if any, leading to immediate	ions,	b	2 (or 25 2	conseque	non of):									
	led Isit	Examiner	cause. Enter Underlyin Cause (Disease or injur	ng -	008 (	9 (01 as a	Conseque	nce or,									
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8760,	icate be executed physician and the burial-transit	dical		l	d												
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Вох	death certifi e attending i id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, o		f pregnand		Catania aranga					23	3d. Date of de	livery	
	9 9 5	icia	in the past 12 mor 1 ☐ Yes 2 ☐ No			gnant at tir	me of dear		Ectopic pregnar Other (specify)						Month	Day	Year
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	es thi	by F	Part II. Other significan	nt conditions o	ontributing to	death but	not resulti	ing in the u	nderlying cause (	given in I	Part I.	23					use of death?
ord	w requir been si should												1 ∐ Ye	s 2L	No 3□P	robably	4 ∰Unknown
ec	has be	ompleted										24	a. Was ar	V	24b. Were a prior to	utopsy i	findings available tion of cause of
= =		Con										10	perform Yes 2	ned?	death? 1 ☐ Ye	s 2	No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred t examiner?	to medical	Henritali						Place of Dea	ath (Chec	ck only on	9)			
of	S 0 0	2	1 Yes 2 No					VOutpatier	I SE DOA		XNursing F	_			Other (Spe	ecify)	
Division of Vital Records,	ding Phy th. After thi funeral	lon		Pending	(Mo	e of Injury onth, Day	Year)	8b. Time of Injury	W	ork?	2 🗆 No	280. Di	escribe ho	w injury	occurred		
isi	r Attendi er death. rector: A by the fu	ical	2 Accident 3 Suicide 6	investigation  Could not b		ce of Injun	v - At hom	e. farm. str	eet, factory, offic			28f. Lo	cation (Str	reet and	Number or F	lural Ro	ute Number
ĕ	al or Attend after death Director: d in by the f	Certification:	4  Homicide	determined	buil	ding, etc.	(Specify)	,,	,, ,			Cit	y or Town	, State)			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	aic	29a. Certifier 1	Certifying Ph	ysician: To th	he best of	my knowle	edge, deatl	occurred at the	time, da	te and place	, and du	e to the ca	use(s) a	ind manner a	s stated	
	n 24 h	edical	(Check only 2 one)	Medical Exar	niner: On the	basis of e inner state	xaminatio	n and/or in	vestigation, in my	opinion	, death occu	irred at th	ne time, da	ate and p	place, and du	e to the	cause(s)
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and title	of certifier	1- 1	/			29c. Lice	nse num	ber		29	9d. Date	signed (Mon	th, Day,	Year)
			> 7	150	andle	1 th	10		D418	00			Г	)ecei	mber 0	7, 2	2005
			30. Name and address						Print)								
			Thomas Bior	ndo, M.	D., VA	MARY	LAND	HEAL'	THCARE S	YSTE	EM, PE	RRY	POINT	C, M.	ARYLAN	D 21	902
	Sta		DEC 0 8 2	Day, Year)	9 32.	Registrar	's Sign tui	The same of the sa									
	Registr	ar	DE0 0 8 7	7002	KALIK	DO.	7										

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12:10 P Day Year **Physician** annon Emmett 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 311 Washington Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 63 Yrs. Director 216-40-3489 9/21/1942 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. N☐Yes 2☐No Wicomico Salisbury Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23e or in and Menial Hygiene. 7 is marked other than "natural", or Items 23e or treumatic event, the Medical Examiner must be 21804 311 Washington Street USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes X☐ No þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Mary Liming Emmett W. Cannon Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: if Item 27 is meny injury or other treum once. 204 Naylor St., Salisbury, MD 21804 Helen Marie Hurt/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/6/05 Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mellitz **Physician** /Medical Due to (or as a consequence of) Examiner condism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed; page this certificete 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) place Plany man Vinter EC 0 7 32. Registrar's Signature State 2005 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year HURCH ENNARD /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EBREW HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. BALTIMORE EVINGDALE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral 1** M 2 □ F Days Hours Min. 216-82-5856 Director -14 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other then "neturel", or Items 23e or 28e-f show treumatic svent, the Modical Eval, it are in sist be notified at PRINCESS Director SOMERSET 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 Yes Give AIR Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Midowed 4 Divorced BLACK Year or Dates: FORCE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other then." Elementary/Secondary (0-12) College (1-4or 5+) ABOREA REATMENT WATER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HURCH ILLIAM ELEANOR YOA1JE 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 is any injury or other treu once. 30257- BOWLAND HILL 200. Location - City or Town, State CIRCLE roc 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ∰Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) EM. 10/05 BELEV 21. Sign sure of Funeral Service Licensee DENNIE SMITH F - ISABELLA ST, SALISBURY, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Event Cardiothrombotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): physician the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Be Completed 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death? page 2 s 2 🗆 No Vital 1 🗌 Yes 2 **N**o 1 TYAS or Attending Physicien: 25. Was case referre examiner? to medical 26. Place of Death (Check only one) Hospital: ٩ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? r of Death Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigati after death 6 Could no be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

To the

31. Date filed (Month, Day, Year) State Registrar

DEC 0 8 2005

N. S. Raj

29b. Signature and title of certifier

Cycpatremio

apallemo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Main St., Suite 32. Registrar's Signature

Reisturstown

D0057465

29d. Date signed (Month, Day, Year)

12/6/05

MD 21136.

Patient known as Wilbur Carr

December   Line   December   De	41377
## As County Name of the Mackacon pipe street and number   As County Name of the Mackacon pipe street and number   Should be provided the pipe street and number   Should be p	3. Time of Death
218-52-1933   1/2 M 2   F   54	eath
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Wilbur F. Carr    19a   Mailing Address (Sheak and Number or Rural Rocks Americal Conference City or Town, State, 21   200   2	10d. Inside City Limits
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Sharcon Carry/wife  20a. Method of Disposition  20b. Helicon of Dispositio	I MOCOLS
Sharcon Carry/wife  20a. Method of Disposition  20b. Helicon of Dispositio	
20b. Place of Disposition, Name of Security, 12 20b. Place of Disposition, 12 20b. Place of Dispositio	Zip Code)
Physician   All Continues   Committee   Continues	r Town State
Printer I more and Chapel, P.A.  23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying-fluid has cardiac correspiratory arrest.  23b. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying-fluid has cardiac correspiratory arrest.  23c. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying-fluid has cardiac correspiratory arrest.  23c. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying-fluid has cardiac correspiratory arrest.  23c. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying-fluid has cardiac correspiratory arrest.  23c. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying-fluid has cardiac correspiratory arrest.  23c. Exampliably list conditions.  23c. Exampliably list conditi	
23. Part : Enter the disease, or compleations that caused the death. Do not enter the mode of dying such as calculat or respiratory sitiest.    Physician   Medical Examiner   Mindedical Examiner   M	
Physician Medical Examiner  Ph	21157
Due to (or as a consequence of):    Due to (or as a consequence of):	Approximate Interval Between Onset and Death
FFEMALE:   23b Was decedent pregnant in the past 12 months?   1	
The part of the pa	olivery Day Year
24a. Wars and autopsy performer?    25   Was case referred to medical examiner?   1   Yes   2   No   Hospital:   Inpatient   2   ER/Outpatient   3   Do   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2   No   Other:   4   Nursing Home   5   Residence   6   Other (Specific Hospital)   1   Yes   2	- A
1   Yes 2   KNo   Total   Impatient 2   ER/Outpatient 3   DOA   Other 4   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other (Specific Month)   Other   A   Nursing Home 5   Residence 6   Other   Residence   Residence 6   Other   Residence   Residence 6   Other   Reside	
1   Matural   2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Form)   29e. Certifier (Check only one)   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Signature and ditted of certifier   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)   29e. Signature and ditted of certifier   29e. Certifier (Check only one)	
2   Accident 3   Suicide 4   Homicide   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Place)   See. Place of Injury - At home, farm, street, facto	*cify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and Alittle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Andrew A. Nolson, MD  31. Date filed (Month, Day, Year)  32. Registrar's Signature	lural Route Number,
Wild Mark and address of person who completed cause of death (Item 23a) (Type, Print)  Andrew A. Nelson, MD Singi Hospital of Baltimore, Baltim	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Andrew A. Nelson, MD Singi Hospital of Baltimore, Baltimo	th. Day, Year)
State 31. Date find (World), Day, 18a1	Belvedere Av
DHMH 17 Rev 1/2001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10a b.c.e.f.per inf 9852 2-16-06 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Rose Camodeo December 10, 2005 9:11 a.m. Ann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20941 Pintail Court Callaway St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛭 F Yrs. Director 115-26-3598 68 April 25,1937 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Broward Margate FL. 1 ☐ Yes 2 PNo St. Mary's - Callaway 33063 10e. Street and Number 7505 NW 5th Court 10f. Zip Code 10g. Citizen of What Country? ō 20620 -20941 Pintail Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ® No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Secretary Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Teresa Origo ပ Anthony Origo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Nicholas Camodeo / Son 20941 Pintail Court, Callaway, Maryland 20620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Raymond Cemetery 12/16/2005 Bronx, New York 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 Kyle S. Simons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 27 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ۾ been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours e To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca and manner stated. 29d. Date signed (Month, Day, Year) 14285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650 William D. Boyd II, 31. Date filed (Month, Day, Year) DEC 12 32 Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

			1 For State	State of Ma		d / Depa		t of H	ealth a	and M	lental Hyg		0.05	41379
			Registrer  1. Decedent's Name (First, Middle, Las	t)				0, 2			2. Date of Deat			3. Time of Death
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	p ,		Usual Residence of Decedent		100 Cit	y, Town or Lo	antion							10d. Inside City Limits
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	iten	S	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🔯			f Yes, spec	ify Cubar	n, Mexican	, Puerto	ecity Yes or No- Rican, etc.)		Black, White,	etc.
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<u>8</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene is marked other than 'naturel,' or iteme 23a or 28e-f show sumatic event, the Mudical Examination and the notified at	2	Eugene Warren											
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Baltimore,	it. Pag intment intent: I injury o		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		110				s of Facilit		000			
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4	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a conseq	uence of)	1 6	uki	w					
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	1 1 1 m		Decedent's Name (First, Middle, Last)			2. Date of De	ath	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Bir (Month, Da July 1	th ly, Year) 9. Birt Co 5, 1955 Was	hplace (State or Foreign untry) hington, DC
	pu 🛊		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
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2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-4 show empty injury or other treumatic event, the Medical Examiner must be notified at anne.	Completed			rofessional		Computer	
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Maryland	2 shc and and is m		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ig Address (Street and Number or Rui	ral Route Numb	er, City or Town, State, Z	Tip Code)
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•	17		MANNE		RES OOD		Dec, 4th,	2005

State

Registrar

31. Date filed (Month, Day, Year)
DEC 08

ass of person who completed cause of death (Item 23a) (Type, Print)

2005

32 Registrar's Signature

5601, Loch Raven Blvd Baltimore. MD-21239

Baltimore.

5. Social Security Number 6. Sex 1 Months Days Hours Min. Society Year)  5. Social Security Number 577-07-0321  Social Security Number 6. Sex 90 Yrs. Hours Min. Days Hours Min. Society Year)  Social Security Number 577-07-0321  Social Security Number 6. Sex 90 Yrs. Hours Min. Days Hours Min. July 11, 1915  Social Security Number 6. Sex 90 Yrs. Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11, 1915  Social Security Number 6. Sex 1 Nonths Days Hours Min. July 11,	
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S. Social Security Number  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  90  Yrs.  Months  Days  Hours  Min.  July 11, 1915  Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Maryland  Montgomery  10f. Zip Code  10g. Citizen of We  3431 S. Leisure World Blvd., #2a  20906	-
The principal Director    State	Birthplace (State or Foreign Country)
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10a. State 10b. County 10c. City, Town or Location  Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code 10g. Citizen of W  3431 S. Leisure World Blvd., #2a 20906	Maryland
Maryland Montgomery Silver Spring  106. Street and Number  3431 S. Leisure World Blvd., #2a  20906  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify: Specify	10d. Inside City Limits
106. Street and Number  3431 S. Leisure World Blvd., #2a  107 Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  108. Street and Number  3431 S. Leisure World Blvd., #2a  10906  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race Black  15. Types 2 NMay 1942- 16. Types 2 NMay 1942- 17. Types 2 No. Specify:  10. Specif	1 ☐ Yes XXNo
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Affred Porces?  1 Never Married 2 Marned   1/2 Pes 2 NMay 1942   1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)   Black   1 Never Married 2 Name   1 Yes, Specify:   1 Yes	- American Indian,
n in tes are no specify: Specify: Specify:	, White, etc.
Specify:    Specify:	White
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Accountant  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Accountant  Stuart	iness/industry
Elementary/Secondary (0-12) College (1-4or 5+)	
2 Accountant Stuart  To = 1.5 feb =	Motor Co.
College (1-4or 5+)   College (1-4or 5+)   College (1-4or 5+)   Accountant   Stuart	,
Hardey Cissel    Bertha Scaggs     19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S	To Corto 20006
Sertrude Cissel/ Wife 3431 S. Leisure World Blvd, #2a, Sil	
Gertrude Cissel/ Wife 3431 S. Leisure World Blvd, #2a, Sil	City or Town, State
1   Burial 2X Cremation 3   Removal from State   September   A   Donation 5   Other (Specify)   Metropolitan Crematory   2005   Alexandr	
20a. Method of Disposition  1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)  20c. Location - (Other place) Metropolitan Crematory  20c. Location - (Other place)  20c. Location - (Other	ia, Virginia
21. Signature of Puneral Home I Francis J. Collins Funeral Home I 500 University Blvd, W, Silver Sp	nc ring MD 20901
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest	Approximate
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  A Due to (or as a consequence of):	1 MONTHS
Examiner	
Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	
Cause (Disease or injury that initiated events	
resulting in death) Last  Due to (or as a consequence of):	
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S	
See a positive of the past 12 months?  O of	of delivery
in the past 12 months?    O   O   O   O   O   O	th Day Year
O est be to	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
1   Yes 2   More and 1   1   Yes 2   More and 1   1   Yes 2   More and 1   1   Yes 2   More and 1   1   Yes 2   More and 1   Yes 3   More and 1   Yes 4   Yes 4   Yes 4   Yes 4   Yes 5   Probably 4 Unknown	
The state of the s	ere autopsy findings available for to completion of cause of
performed? de	ath? □Yes 2⊡7No
The state of Death   Check only one	
Of the control of the	
The standard of the standard o	i .
2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	
27 Manner of Death 1	of Hural Houle Number,
5 6 6 9 Q	
29a. Certifier  Check only one)  29a. Certifier  (Check only one)  29a. Ce	id due to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed	(Month, Dey, Year)
1+1 DESTAND D516/6 12/06	1
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NULSON Kalil 1811 Prince Philip Drive #327,01NP4, MD 200	231
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	)
Registrar DEC 0 8 2005 Show Mr.	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/24/2005 **Physician** Sophie Dixson 1:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Days none 89 Yrs. 12/24/1916 Director Sierra Leone Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural, or keme 23a or 28e-f ehow the Medical Examiner must be notified at 1X Yes 2 No Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 11200 Lockwood Dr. 20901 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) I 2 t h College (1-4or 5+) Carpenter Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Dixson Sofiatu Dixson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sophie Cole-Foster/Granddaughter135 Rizal Drive Hillsborough CA 94010 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/3/2005 Landover, MD Harmony Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.P. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd. Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hes 1□ Yes 1 Yes 2□ No 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 MI OA funeral 28b. Time of 28c. Injury at Work? 27. Mannes of Death 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide To the Hospitei o within 24 hours aft To the Funerei Di 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO043539 Laymond ess of person who completed cause of death (Item 23a) (Type, Print) Raymond M. White, MD 1500 Forest Glen Rd. Silver Spring, MD 20910 31. Date filed (Month, Day, Year) P. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar		artment of I rtificate of		d Mental Hy	ygiene 05	41383
	Physici	an	1. Decedent's Name (First, Middle, La	~				2. Date of D Month	Day Y	3. Time of Death
. E	/Medic		4a. Facility Name (If not institution, gir	ye street and number)	ay	4b. City, Town,	or Location of D	1 2 Death	4c. County of	,0,
	Examin	ier	University of	Marylandt	tospital	Bal	timor		$\sim$	/A
	Funeral		,		In yrs. last birthday,	If Under 1 Year Months Days		Hrs. 8. Date of B	irth 9 ay, Year)	Birthplace (State or Foreign Country)
	Director	ŝ.	214-12-5128 Usual Residence of Decedent	TASM 2UF	84 Yrs.			Aug. 19		Maryland
	land ow		10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	the Marylar 28s-f show	tor	MD Worces	ter	Snow Hi	11				1 ☐ Yes 2 X No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	rai	6655 Snow Hill 1			21863			U.S.A.	
	ltems ner de	nue	11. Marital Status  1 ☐ Never Married 2 ☒ Married	12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No	er in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin pan, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	lo- 14. Race - Black,	American Indian, White, etc.
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WW II	1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Exeminar must be natified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed	16a. Dece	dent's Usual Occu	pation	f working	16b. Kind of Busi	ness/Industry
121	vithin ne. hen "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire			D 14	C
	Hygie Hygie ther t		17. Father's Name (First, Middle, Las	t)	Main	tenance M			Pump Man e, Maiden Surname)	ufacturer
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental hygiene. Itam 27 is marked other than "natural", or Items 23a or 28s-f show other traumatic event, the Medical Experiment must be notified at	To Be	Peter Walter Do	,					on Donoway	7
ary	shou and M s mar umat	F	19a. Informant's Name/Relationship	-	19b. Mail	ng Address (Street	t and Number o	or Rural Route Numi	ber, City or Town, St.	ate, Zip Code)
	1 and 2 Health a lam 27 is	1	Doris Pruitt Do			5 Snow Hi	11 Road		Hill, MD	21863
Baltimore,	tges 1 at of Ha if iter or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 [	70	20b. Place of Disp cemetery, cre	matory or other pla	ice)	Date	20c. Location - Ci	ty or Town, State
Ë	permit. Pa Departmen Important: any injury once.		4 Donation 5 Other (Special		Trinity G of Memori			. 9, 2005	Newark,	Maryland
Ba	permit. Pages 1 and Department of Heal Important: If Itam 2 any injury or other Once.		21. Signature of Funeral Service Lice	INS66		2. Name and Addre Short Fur 13 E. Gro	neral Ĥo	ome Delmar,	DE 19940	)
9		ì	23a. Part1. Enter the disease, or co- shock, or heart failure. List only	polications that caused the one cause on each line.	e death. Do not en	ter the mode of dy	ing, such as car	rdiac or respiratory	arrest,	Approximate Interval Between Onset and Death
*	Physician		Immediate Cause (Final disease or condition resulting in death)			tion My	10 carch	ial In fa	anction	Oriset and Death
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30,	sate be executed oblysician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	cate b physic the b	Physician/Medical	•	d						
Box 6	that the death certifics ed by the ettending pt detached for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date (	of delivery
	death e etter d for u	iciar	in the past 12 months?	1 ☐ Live birth 2 ( 4 ☐ Pregnant at tir		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	;y		Month	
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	es pe	Ď	Part II. Other significant conditions	contributing to death but r	not resulting in the t	ınderlying cause gı	ven in Part I.	23e. Did	/ _	ute to the cause of death?  ☐ Probably 4 ☐Unknown
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Re	The lay te has age 2	отр			<del></del>				opsy prio formed? dea	or to completion of cause of the lith?  Yes 2 No
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of V	Physician: this certificaral director, i	ို	1 ☐ Yes 2 XVo	Hospital: 1 Inpatient		III JUDOA			sidence 6 Other	
OU C	Jing P	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (	Wo	ryat ork? ]Yes 2 □ No		how injury occurred	
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Ξ	al or / s after il Dire	Certification:	4  Homicide determined	building, etc. (	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, State)	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier 1 Destrifying P (Check only one) 2 Medical Exa	hysician: To the best of r miner: On the basis of ex and manner state	kamination and/or ir	th occurred at the to	ime, date and p opinion, death o	place, and due to the occurred at the time	e cause(s) and mann o, date and place, and	er as stated. d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1.00	ND	29c. Licen			29d. Date signed (i	
	8003		P 11. yarba				5715	1/4	12/7	2005
	1,78		30. Name and address of person who	completed cause of deal	th (Item 23a) (Type Bal 1	Print) N, Z	"M"D"	2120	1	
The state of the s	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Registrar's	Signature	barles				

			For State Registrar	State of Ma		I / Departm <i>Certific</i>	ent of H	ealth and	•		2005	41384
	Physicia		Decedent's Name (First, Middle, and I all and I am	Last) Dombro	مريجاد غ				2. Date of D Month	eath Da	ay Year	3. Time of Death
	/Medica	al	Helen		OMRY		No. Tour	Landing of Book	12	06	c. County of Deat	18:45-PM
	Examine Funeral Director		4a. Facility Name (If not institution, s PENINGULA REG 5. Social Security Number 16 125–05–0139	Sex 7. Age	edical (In yrs. Ia 136	Center	nder 1 Year	Sn Lisbe If Under 24 Hrs Hours Min.	IRY 8. Date of B		Wice	f
	pug *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Location						10d. Inside City Limits
	a-f eho	ctor	,	omico	-	alisbury						1 Yes 2 □ No
	th with th	ai Dire	10e. Street and Number 1109 S. Schumak	er Drive		10f	Zip Code 21804	1		10g. C	itizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be motified at SIGE.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:			ecedent of Hi specify Cuba s 21X No	ispanic Origin? (5 n, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	10-	14. Race - Ame Black, White Specify: W	
15-0	n 72 ho	ieted	15. Decedent's (Specify only highest	grade completed)		16a. Decedent's (Give kind o	Jsual Occupa f work done of T use retired	ation during most of wo	nking	16b. h	Kind of Business/	Industry
212	y withi	ошо	Elementary/Secondary (0-12)	College (1-4or 5+	·)	Homema		,		Do	omestic	
Baltimore, Maryland 21215-0036	uld be fited Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, La Alexander Uszko		,			18. Mother's Na Mary	<sub>me (First, Midde</sub> Peniaze		n Sumame)	
Man	nd 2 sho alth and the 27 is ma		19a. Informant's Name/Relationship Robert Dombrows			19b. Mailing Add					or Town, State, 2 MD 2180	
more,	ages 1 a ent of Hea nt: If Item y or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		1	nce of Disposition metery, crematory  vary Cem			Date /9/05		ocation - City or	
Balti	permit. I Departm Importa eny inju		21. Signature of Funeral Service Lic			22 Nam HOI]	e and Addres	s of Facility uneral	Home Pr	ofes		ssociation
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final			Do not enter the	mode of dyin-	g, such as cardia	c or respiratory	arrest,	,	Approximate Interval Between Onset and Death
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3760,	ite be nysicie ne bu	icai Examiner	hat initiated events resulting in death) Last	c.  Due to (or as a	conseque	ence of):						
<i>k i</i> .0. Box 68	that the death certificaled by the attending phidetached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnapt in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal	death 3□Ectop	ic pregnancy (specify)				23d. Date of deli Month	ivery Day Year
rows ords, P	The law requires that the has been signed brage 2 should be deta	ed by PI	Part II. Other significant condition:	13RILLAT	70 A	/		en in Part I.				the cause of death?
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_	se Hospital	Medical C	29a. Certifier (Check only one)  12 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of earn manner state	examinatio	rledge, death occur on and/or investiga	red at the tim ition, in my of	ne, date and place pinion, death occ	e, and due to th urred at the time	e cause(s	s) and manner as id place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. License	number			ate signed (Month	
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	Stat , Registra		31. Date filed (Month, Day, Year) DEC 0 8	2005 32. Registrar		y. Soan	1					

		-	State of Maryland	/ Depa		Health and	•	•	4   385											
Physicia /Medica Examine	ıl -	1. Decedent's Name (First, Middle, Last) Robert Melvin Dail 4a. Facility Name (If not institution, give str Chesapeake Woods (	reet and number)		4b. City, Town,	or Location of Deat	2. Date of D Month	Day 20 4c. County of	Year 3. Time of Death 0330 M											
Funeral Director		5. Social Security Number 6. Sex 154	7. Age (In yrs. lasi 85	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of B (Month, D		9. Birthplace (State or Foreig Gountry) Maryland											
e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Dorcheste	10c. City, 1		ention ambridge				10d. Inside City Limit											
ath with the 23s or 20	Funeral Director	1017 Hudson Rd.		1	10f. Zip Code	21613		10g. Citizen of WI	SA											
		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerl	pecify Yes or N o Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White											
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od otha	10 Be	17. Father's Name (First, Middle, Last) Willie S. Dail			Smerit ope			e, Maiden Surname												
Health and Meritam 27 Is market other traumatic		19a. Informant's Name/Relationship (Type Elmira Hoswell Dail	L/Spouse	1017	Hudson I	Rd., Camb														
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Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Advanced  Due to (or as a consequent  Chomic 3	PA7	kinson	s dis	PHST		Interval Between Onset and Death											
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ath certificate be attending physicial for use as the but	cai	cai	Physician/Medical E	cai	cai	cai	cal	g	icai Exa	Ca	ca	Ca	in the past 12 months?	s. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	ath 3	Ectopic pregnanc	у		23d. Date Monti	•
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has been signinge 2 should be	ompleted by	Asthma					1 🗆 24a. Was	s an 24b. We	☐ Probably 4 ☐ Unknown  are autopsy findings available or to completion of cause of											
	ַ ב	25. Was case referred to medical examiner?				26. Place of Dea	perf 1 Tes	ormed? de 2☐₩0 1☐	ath? Yes 22No											
<u> </u>	2	1   Yes 2   No Host  27. Manner of Death   Natural 5   Pending 2   Accident investigation		Outpatien  Time of Injury	28c. Inju Wo	ry at		idence 6 Other												
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within 24 hours a To the Funeral Completely filled	edical	29a. Certifier Certifying Physic (Check only one) CHOISE CERTIFY CHIEF C	r: On the best of my knowle r: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manr , date and place, an	ner as stated. d due to the cause(s)											
To t com	A	29b. Signature and title of certifier  Me My 4500	lumo		29c. Licens			29d. Date signed (												
and the second second		30. Name and address of person who com  Michael J FALL	pleted cause of death (Item 23	la) (Type, I	Print) Collins	/per	lock 1	Dec 8,	1643											
State Registra	100	31. Date filed (Month Day Year) 8 20	32. Pigistrar's Signature	× 4	berte															

/Medical Examiner attending physician and for use as the burial-transit certificate be executed P.O. Box 68760 signed by the a d be detached for Division of Vital Records. peen certificate has this

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BURTON FAIRALL DAVIS Dec 2005 11:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Genesis HealthCare -The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **XX**M 2□ F Days Hours Yrs. Director 85 006-12-2049 1920 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CANDLE LIGHT COVE 21601 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3XWidowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES ADVERTISING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILTON E. DAVIS RUTH WILHELM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOHN C. DAVIS / SON 108 FOX RUN LANE STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER 12/9/05 1 Burial 2 Cremation 3 Removal from State STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON STREET EASTON, MD 21601 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive **Physician** hears Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending P 24 hours after death. e Funerel Director: After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 1 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Kem 23a) (Type, Print) 610 Rowhi CHMANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 3 2005 **Physician** Henrietta H. Davis 9:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Heritage Harbour Health & Rehab Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 19 5. Social Security Number 9. Birthplaca (State or Foreign 6. Sex **Funeral** Days 1 ☐ M 21 1 F 215-32-0630 85 1920 Maryland Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or Iteme 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Lothian 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 5058 Sands Rd. 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black ð 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Family 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Harrison Daisy Pindell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Colbert(Grandaughter)|1535 Hickory Wood Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of Beatland, artificial) a 1 Date 20c. Location - City or Town, State permit. Pages Department of Important: If II any injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Park 12-8-05 Annapolis, Md. 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, Lavy B. Beese MOS 483 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ans /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown s been signed by the should be detached Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 38958 MIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highway sw ofin Burnie MD 2061

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, DEC

32. Registrar's Signature

			Amend Item 23state of Maryland / Dep 1-State per Dr., G851, OL/	partment of Health and N 12/06dhb Pritificate of Death	Mental Hygie	ne 005	41388
I			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Frances L. Dutrow		Dec. 5		8:00 p M
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			300 Fernwood Drive	Severna Par			Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 日本 2 以下 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	1927 9. Birti	hplace (State or Foreign untry)  MD
	_		220-20-0071 775.  Usual Residence of Decedent		Nov. 16,	1321	74177
	yland		10a. State 10b. County 10c. City, Town or L	_			10d. Inside City Limits
	Ba-f	ctor	MD Anne Arundel	Severna Park			1 ☐ Yes 2₹ No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	•
	death with the Maryland me 23a or 28a-f ehow r must be notified at	ral	300 Fernwood Drive	21146	anit. Van an Na	USA 14. Race - Ame	
	ter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
99	urs af	by	3 XWidowed 4 □ Divorced	1 ☐ Yes 2X No Specify:		Specify:	White
Š	72 ho	Completed		edent's Usual Occupation e kind of work done during most of won	16	b. Kind of Business/	Industry
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2	led w tygier her th	Cor	12 17. Father's Name (First, Middle, Last)	Secretary	ne (First, Middle, Ma	W.R. Gr	ace
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28a-f show aumatic event, the Medical Examinat must be notified at	Ве	George R. Doty	Agnes		den Sumame)	
2	hould d Me mark matic	욘		ling Address (Street and Number or Ru		itv or Town, State, 2	Zip Code)
2	₽ £ M ≥ 0			Fernwood Drive,		•	21146
ē,	s 1 a		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or	Town, State
Ë	Pages nent of int: If It iry or o			erans Cemetery	2005	Crownsvill	le, MD
	permit. Pages 1 an Department of Heal Important: If Item 2 ony injury or other ance.		21. gnature Funeral Service Licensee	22. Name and Address of Facility Barranco & Sons, P		na Park Fi	meral Home
<u> </u>	8258		CANIES UN ONZUM	195 GOV. RITCHIE H	wy, Severi	na Park, M	1D 21146
п			23. Part1. Inter the disease, c. co. plications that caused the death. Do not en shock, or heart failure. Lis on one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	r	Approximate Interval Between Onset and Death
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		-E	Sequentially list conditions, b.				
	uted d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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8760	cate be executed physicien and the burial-transit	dical	d.				
39	artifica ing pt e as t	Med	IF FEMALE:				
Вох	death certific e ettending p ed for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 meeths?  23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deli	v <i>er</i> y Day Year
o	0 0 0	yslc	1 □ Yes 2 ☑No 4□ Pregnant at time of death 5 9 □ Unknown	Other (specify)			
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rds	quires n sigr uld be	d by			1 ☐ Yes	2 12 No 3 □ Pro	obably 4 Unknown
000	₹ 17 W	olete			24a. Was an	34b. Were au	topsy findings available completion of cause of
Ä	The law te hes to bage 2 s	Completed			autopsy performe 1 ☐ Yes 2 ☐	d? death?	
ita	ian: ortifice ctor, j	Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)		
<u>&gt;</u>	Physician: The la r this certificete hes ral director, page 2	일	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 □Other (Spec	cify)
Division of Vital Records,	ling Afte Tune	lon:	27. Mannar of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how	injury occurred	
<u>s</u>	Attending Physician: or death. ector: After this certific by the funeral director,	lcat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm s		28f. Location (Stree	et and Number or Ru	ral Route Number
<u>^</u>	after after Dire	Certification:	28e. Place of Injury - At home, farm, s building, etc. (Specify)	and the state of t	City or Town, S		,
	To the Hoepital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ith occurred at the time, date and place	and due to the caus	se(s) and manner as	stated.
	the Hin 24 the Figure 24	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or i and manner stated.				
	To Son	2	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	
7			(Jest)	100/01/	1	ecert.	4 2005
			30. Name and address of person who completed cause of death (Hem 23a) Type  Ch 160 R Delwin 7	tospital Vene, G	19, Buny	rel. 210.	6/
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 7 2005  32. Restrar's Signature	book			,

			1- State of Maryland / Department of Health and Certificate of Death	d Mental Hy	giene 105 41389
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) William Robert Disharoon	2. Date of De Month	Day Year 8:15 P M
	Examin Funeral	er •••	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De  Atlantic General Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24 H	frs. 8. Date of Bir	4c. County of Death  Worcester  th (2) (Park)  9. Birthplace (State or Foreign Country)
le i	Director		220-12-0552 12 Months Days Hours M		4, 1925 MD
	ith the Maryland or 28a-f show	tor	10a. State 10b. County 10c. City, Town or Location Md Worcester Newark		10d. Inside City Limits 1 ☐ Yes 2∕☐ No
	with the a or 28s	Direc	10e. Street and Number 10f. Zip Code 6953 Gunning Club Lane 21841		10g. Citizen of What Country?
036	permit. Pages 1 and 2 should be fited within 72 hours atter death with the Maryland Department of Heelih and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No  1 ☑ Yes 2 □ No  1 □ Yes 2 ☑ No Specify:	(Specify Yes or No erto Rican, etc.)	US  14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036	ad within 72 ho giene. er than "natur i, the Mad cal	Completed	15. Decedent's Education (Specify onfy highest grade completed)  Elementary/Secondary (0-12) 9  16a. Decedent's Usual Occupation (Give kind of work done during most of wild life. DO NOT use retired) Farmer	working	Agriculture
yland	ould be fite I Mental Hy wrked oth	To Be (	Ernest Preston Disharoon Mabel	Fulton F	
Mar	eith and 27 is rr		19a. Informant's Name/Relationship (Type, Print)  Dawn Webb (daughter)  19b. Mailing Address (Street and Number or 6953 Gunning Club La		W. 1000 1000 1000
more,	Pages 1 a ent of He nt: If Item ry or other	1	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City or Town, State Berlin, Md.
Baltiı	permit. F Departm Importer any injur		21. Signature of Fund Service Licensee  22. Name and Address of Facility T  108 William St.,	he Burbag	ge Funeral Home
-4-4-1425 -6-2005 8760,	ate be executed hysician and hysician and hysician five buriat-fransit	licai Examiner	23a. Part. Enter the disease, of complications that raused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause or lack line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition. The properties of the cause in the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Riac or respiratory a	Interval Between
0.0.8 - Cro 12- 0. Box 6	es that the death certifice igned by the attending pr be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Fetal death 3  Ectopic pregnancy 5  Other (specify)		23d. Date of delivery Month Day Year
S.L. rds, P.	quires that the signed by all be detacted	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
W . W al Reco	n: The law requir icete has been si r, page 2 should	Completed		1 ☐ Yes	psy prior to completion of cause of death? 2☑No 1 ☐ Yes 2☐ No
Disharoon Division of Vit	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification; To Be	Avanuary 1	28d. Describe	dence 6 Other (Specify) how injury occurred  Street and Number or Rural Route Number,
Div	Hospital or , , , , , , , , , , , , , , , , , ,		29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	City or To	cause(s) and manner as stated.
	o the Ho ithin 24 f o the Fu ompletely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or	ccurred at the time.	date and place, and due to the cause(s)
	To To cor		29b. Signature and title of certifier  29c. License number  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  DEC 0 8 2005  32 degistrar's Signature	3	12/6/05
8	T 10+1		30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Robert Dulled During 133	Drive	· Berlin, m A
	Sta Registr		31. Date (iled (Month, Day, Year) DEC 0 8 2005  32 degistrar's Signature		

			For State			d / Depa	artment of H	lealth and N			105 /	1300
			State Registrar			Cel	tificate of	Death		Reg. No.	, , , ,	* 1 0 0 0
	Physici	an	1. Decedent's Name (First, Middle,						2. Date of Dea Month	Day .	a 2005	3. Time of Death
	/Medic		4a. Facility Name (If not institution,	ce Madal		nglis		r Location of Death	Decemb		ounty of Death	3,001 "
1	Examin	ier	Dorches	er Can	eral	LISD	Car	shrida	د	D	orche	stor
	Funeral				Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	h Vansi		lace (State or Foreign try)
	Director		218-24-4034	1 □ M 2 🔀 F	75	Yrs.	Months Days	Hours Min.	September	4, 19	30 Ma	ryland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	cation	-				0d. Inside City Limits
	faryla sho se at	5			100.01						1"	1 1 Yes 2 □ No
	28a-	Director	Maryland Do: 10e. Street and Number	rchester		Hurl	OCK 10f. Zip Code			10g. Citize	en of What Coun	try? America
	3a or		204 Broad Str	aet			21643				ed Stat	
	death	Funerai	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13. \		dispanic Origin? (Sp an, Mexican, Puerto			Race - Americ	an Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Marrie				l Tes, specily cubi		ricali, etc.)	i	Black, White, of pecify:	etc.
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-1 show Ite Madical Exeminan musi be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Date	s:						Cauca	asian
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0	should be filed within 72 hc nd Mental Hygiene. merkad other than "natur matic evant, the Medical	Be C	17. Father's Name (First, Middle, La	ist)		50.51	2117,500	18. Mother's Nam	e (First, Middle,			
lan	ould be Mental arkad o	To B	Leonard	H:11				Sarah	Elizak	neth	Jestei	r
Maryland	should and Men Is marka	_	19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street	and Number or Rur				
	rtr		Virgil A. Hil	l, Sr.	Son	204_	Broad S	treet, I	Hurlock	c, Ma	aryland	1 21643
ore			20a. Method of Disposition 1   Burial 2 □ Cremation 3	□Removal from Sta		lace of Dispo emetery, cren	sition (Name of natory or other plac	се)	Date	20c. Loca	ation - City or To	wn, State
Ë	nit. Pages artment of ortant: If it injury or o		* 4 ☐ Donation 5 ☐ Other (Spe	ocify)			Cemeter				ton, Ma	aryland
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Li	hand	_	M	. Na <i>m</i> e and Addre	neral Ho	ome, P.	Α.		21629
	40=00		23a. Part1. Enter the disease, or c	y 1000	and the death	Do not ont	2_South	Second	Street	De	enton,	Maryland Approximate
			shock, or heart failute. List of	nly one cause on each	n line			-		1651,	1	Interval Between Onset and Death
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Р	Examiner			Due 10 (01	as a consequ	derice or):						
	200	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequ	uence of):						
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68760,	ate h	dical		d								
9 X	leath certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outcome	me of pregna	nev						
Вох	atten atten for us	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		230	<ul> <li>d. Date of delive</li> <li>Month</li> </ul>	ry Day Year
P.O.	at the de by the a tached	ıysıc	1 □ Yes 2 ဩNo 9 □ Unknown	9□ Unknowi		50.11	Other (specify)					
	s that ned b a deta	by Pr	Part II. Other significant condition				nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
rds	quires an sign uld be	ed b	chronic obstru	ctive pulmo	mary d	isease,			1 <b>★</b> Y	es 2 🗆	No 3 ☐ Proba	ably 4 Unknown
ecords,	aw requ s been 2 shoul	Completed	Non-STelevation			retion			24a. Was a			sy findings available
$\Xi$	The lav	E O		1					autop perfor	med?	death?	npletion of cause of 2 No
Vital	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Deat				
of V	Physician: r this certifica ral director, i	2	1 ☐ Yes 2 X No	Hospital: 1 Kinp		ER/Outpatien		4 Inursing Ho	me 5 ☐ Resid	ence 6	Other (Specify	)
	ding P h. After t funera	on:	27. Manner of Death 1 XNatural 5 ☐ Pending		njury Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	ow injury o	occurred	
isio	or Attanding ifter death. Diractor: After in by the fune	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	Injuny At ho	mo form at-		Yes 2 □ No	29f Location /S	troot and I	Nu <i>mber or Rur</i> ai	Pouto Number
Division	after all in by	Certification:	4 ☐ Homicide determin	ed 288. Flace of building,	etc. (Specify	/)	eet, factory, office		City or Tow		vuilibel of Hural	noute Number,
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the be	st of my know	wledge, death	occurred at the tir	ne, date and place,	and due to the o	ause(s) ar	nd manner as sta	ated.
	na Ho 1 24 h ne Fui letely	edicai	(Check only 2 Medical Exone)	caminer: On the basi and manner	s of examinat	tion and/or inv	restigation, in my o	pinion, death occur	red at the time, o	late and pl	lace, and due to	the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifler	(1) 1	0		29c. Licens				signed (Month, L	
			· UU	I hall	M.	D.	D	50804		Decen	uber Il,	3005
			30. Name and address of person w	no completed cause of	of death (Item	23a) (Type,	Print)	mbridge,				
			Mark Malke	G, M.D.	408 13	you St	reet Ca	mbridge,	MD 3	1613	•	
	Sta Registr	• 4	31. Date filed (Month Ec Year)	2005 32. Reg	istrar's Signa	ture	hour ?	•				
		3		A Prince	-	10	Shares - Christian					

		í	State of Maryland / Dep	artment of Health and Mertificate of Death		ene 2.005	41391
			Decedent's Name (First, Middle, Last)		2. Date of Death	-	3. Time of Death
	Physici		Alvin Erskine Edwards		Month December	Day Year 5,2005	7:40 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	beccmber.	4c. County of Deat	
	LAUITIN		Caroline Hospice	Denton		Caroli <sub>1</sub>	ne .
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	O Rist	hplace (State or Foreign
	Director		266-23-1101 1®™ 2□ F 70 Yrs.	Months Days Hours Min.	(Month, Day, ) Feb. 24,	1935 Bart	pados.W.I.
	D		Usual Residence of Decedent			700   2001	
	how		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Ba-f s	cto	Maryland Caroline Preston				1 ☐ Yes 2 No
	ith th	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	ountry?
	23a	- a	4499	21655		USA	
	r des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
2	or h		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 Yes 2 No Specify:		Specify:	
	urel.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			West	Indian
5	nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation o kind of work done during most of workin DO NOT use retired)	ng 16	b. Kind of Business/	Industry
V	withir	E G	Elementary/Secondary (0-12)   College (1-4or 5+)	Keeper	Λ.	ma Martinat	
V	be filed within 72 hours after death with the Maryland ital Hygliene. Ide other then "naturel", or items 23a or 28a-f show other then "naturel", or items 23a or 28a-f show event, the Medical Examiner must be reciffed at	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name		ome Market	S
2	ntal l	<u>m</u>					
	hould d Me mark matic	T <sub>o</sub>	Harold Edwards  19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Violet ing Address (Street and Number or Rura	Boune		7in Code)
2	iges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If item 27 is marked other then "naturel," or items 23a or 28a-f show or other freumatic event, the Madical Examinations is interested to the file of or other freumatic event, the Madical Examinations.						,,
נפ	1 an Heal em 2		20a. Method of Disposition 20b. Place of Disp	Nelpine Road, Pre		C. Location - City or	
2	ages nt of nt of :: If it		1 Burial 2 □ Cremation 3 □ Removal from State Cemetery, cre	matory or other place)			
Dallimor	it. P.			r Memorial 12-09-	·2005   Pi	eston,Mar	yland
מ	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre		M. Oli De Pose de	Bennie Smith Funer 426 Dover Street,	ral Home		1.001
			23a. Part1. Enter the disease, or complications that caused the death. Do not en				1601 Approximate
			shock, or heart failure. List only one cause on each line.		i lespiratory alles	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	carcin'ona			
	Examiner		Due to (or as a consequence of):				
		<u>a</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ited	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury				
	al-tra	Xal	that initiated events c. Due to (or as a consequence of):				
9	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical					
00	ficate g phy as the		V				
Š	nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7-		23d. Date of deli	ivery
	death a atte	icia	in the past 12 months?  1 Yes 2 No.  1 Yes 2 No.	□Ectopic pregnancy □ Other (specify)		Month	Day Year
2	t the oy the ache	hys	9 Unknown				
L	s thai ned t	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ë	quire n sig uld b	pg Ir	Renal cell carcin's	ma	1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
ecords,	s bee	Completed			24a. Was an	24b. Were au	topsy findings available completion of cause of
ב	The la	mo			autopsy	d?   death?	completion of cause of 2 ☐ No
	en: T	a)	25. Was case referred to medical	26. Place of Death		No 1 □ Yes	2 LI NO
>	ysicil s cer direct	0.0	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other		ce 6 Other (Spec	Hospice
0	g Ph er thi	n; T	27. Manner of Death 28a. Date of Injury 28b. Time		8d. Describe how		House
0	ath. r: Aft	atio	Y Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No			
UNISION	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number or Ru	ral Route Number,
5	s afte	Certification;	Building, etc. (Specify)		Ony or rown,	Statey	
	ospit hour uner ly fills		29a. Certifier (Check only (Ch	th occurred at the time, date and place, a	and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	one) and manner stated.		od at the time, date	and place, and due	to the cause(s)
	vith To 1	Σ	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month	n, Day, Year)
	1		I was lett mo	D5/630	1	10803	>
	< A		30. Name and address of person who sompleted cause of death (Item 23a) (Type	Print)	1	7	27.20
	<i>, </i> フ		Chopian K Comm. Health 60	y Juffin Line	vento	nmod	21027
	Sta		31. Date filed (Menth, Day, Year) 32. Registrar's Signature	A.			
	Registr	ai					

		for State Registrar	State of Marylar	nd / Depa			•	giene Reg. No	000	41392
ki 🔭		1. Decedent's Name (First, Middle, Last)					2. Date of De	aath Dav	. Van	3. Time of Death
Physicia /Medic		Wayne For	lkes				Novemb			1:30p <sup>M</sup>
Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Dea	ith		County of Deat	
		916 Capitol Heigh	ts Blvd.		Capit	ol Height	ts	P	rince Ge	orges
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	r If Under 24 Hr	s. 8. Date of Bi	rth	9. Birtl	oplece (State or Foreign
Director		229-96-1606	M 2□F 4	/ Yrs.	WOTHIS Days	s Hours will	March 2	2, 19	958 Pete	rsburg, Va.
۵ >	-	Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Lo	ention					40d Jacida Cibul imita
aryla shov	2			•	l Height	c				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
88 -f	Funeral Director		eorges	сартьо.						
with the or 2	Ö	10e. Street and Number			10f. Zip Code				izen of What Co	•
ath v	rai	916 Capitol Height			207				ted Stat	
er de Item	nu	The state of the s	2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	0+	<ol> <li>Race - Ame Black, White</li> </ol>	
s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify: Bla	ick
tural hour	pa	15. Decedent's Educ		16a Dece	dent's Usual Occu	ination		165 K	ind of Business/l	ndustra
in 72 in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	e during most of wo	orking	100. K	ind of businessy	rioustry
with ene.	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	Vor	ox Techn	ioian		D-	rivate	
Hygi diled	Ö	17. Father's Name (First, Middle, Last)	3	Aer	JX TECHII		ame (First, Middle			· · · · · · · · · · · · · · · · · · ·
d be antal ked c	To B	Thomas Fowlkes				Alice	Dritch			
shoul mari mati	ř.	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Stree	at and Number or F		er, City o	r Town, State, Z	ip Code)
nd 2 :		Angeles Fowlkes								s,Md.20743
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be intillified at once.		20a. Method of Disposition			sition (Name of natory or other pla	-	Date		ocation - City or	
ages ontology or if		1 ☐ Burial 2 ☐ Cremation 3 ĀR  1 ☐ Donation 5 ☐ Other (Specify)	anioval itotti State			'	.16,2005	Dot	archura	Va
nit. P artme ortan injur		21. Signature of Funeral Service Lifense		20	e Memori	ress of Facility	0.077 3		2019	
Depa Depa Impo any i		to of	. Harne	-	Alexande	Iboro PPI	Funera	1 Hou	pes, P.A	20747
THE REAL PROPERTY.		23a, Pal 1. Et er the diseast, or compl	ations that caused the deal	-					LC, III.	Approximate
		shock, of heart failure. List only on Immediate Cause (Final	e cause on each line.	. 0		<b>3</b> ,	,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	_Natura	e Car	sis					
Examiner			Due to (or as a consec	juence of):	ی					
	<u>.</u>	Sequentially list conditions,	Due to (ar as a consec	uence of):						
ited Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							ľ	
al-tra	Xal	that initiated events cresulting in death) Last	Due to (or as a consec	(uence of):	<del></del>		<del></del>			4.4.564
ate be executed hysician and the burial-transit	icai									
ficate g phy is the	edic									
leath certifica attending ph	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna						23d. Date of deli	verv
death death for atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnant Other (specify)	су			Month	Day Year
the cather	Jysi	9 Unknown	9□ Unknown							
ries that the de signed by the a	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did 1	obacco u	ise contribute to	the cause of death?
ld be							1 🗆	Yes 2	No 3 □ Pro	bably 4 Unknown
w requir been si should	ompieted						24a. Was	an	24b. Were au	lopsy findings available
he lav e has	mo						auto	psy ormed?	prior to death?	ompletion of cause of
sician: Th certificate rector, pag	် ပေ	25. Was case referred to medical					1 Yes		1 🗆 Yes	2 No
sicial certi	o Be	examiner?	ospital:	Irp/o		sh	eath (Check only			
ding Phys	$\vdash$	27. Manner of Death		ER/Outpatier 28b. Time of	I JU DON	4   Iddising	Home 5 Resi			ity)
ding Afte	tion	12☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	We	ork? □Yes 2□No			,	
Mitten deat ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm str			28f. Location (	Street an	d Number or Ru	ral Route Number,
after Direction by	ertii	4 ☐ Homicide determined	building, etc. (Special	(y)	cot, ractory, critica	,	City or To			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	owledge death	occurred at the	time date and place	e and due to the	Called/e/	and manner as	stated
8 Hos 24 h 9 Fur etely	edical	(Check only 2 Medical Examir one)	er: On the basis of examina and manner stated.	ation and/or in	estigation, in my	opinion, death occ	urred at the time,	date and	place, and due	to the cause(s)
omple	Me	29b. Signature and title of certifier	10		29c. Licen	nse number		29d. Dat	e signed (Month	. Day, Year)
F ≤ F ö		10-0	V		.4 ^	S . 9	201	1 1	1/1-	5
		30. Name and address of person who co	moreted cause of death floor	n 23a) (Tuno		0045	181	-10	-1610	)
(6)		1221 Mercantile	Lare las	50. M		74				
Stat	6	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature _	See.					
	<b>.</b> .	DEC 0 8 2005	Lea L		4					

DHMH 17 Rev 1/2001

Physician	1 - State Registrar Amended it  1. Decedent's Name (First, Middle, La	ist)		_		<ol><li>Date of Dea Month</li></ol>	th Day Yea	
/Medical		Branch	Faison	Sr.	s Lanction of Death	DEC.	5 2005	
kaminer	4a. Facility Name (If not institution, give	e street and number)	6-1-	4b. City, Town, or	Location of Death		4c. County or D	eath
	5. Social Security Number 6.5	Dal Medical Sex 7. Age	(In yrs. last birtho	fav) If Under 1 Year	SDU/Y If Under £4 Hrs.	8. Date of Birth	W/60/	<b>171</b> (O) Birthplace (State or Foreign
neral ector		1 <b>∑</b> M 2□F	75 Yr	Months Days	Hours Min.	9/11/19	. Year)	aryland
	Usual Residence of Decedent							
_	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes ※☐ No
Directo	Maryland Wicomi	co	Salisb					
Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
rai	209 Hall Drive	T	- 110	21804		-7. 1/	USA	
Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent E Armed Forces?	ever in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No- Rican, etc.)		merican Indian, /hite, etc.
by F	3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 □ N If Yes, Give A Year or Dates:	irForce	1 ☐ Yes 2 ☐ KNo	Specify:		Specify:	white
ed	15. Decedent's E	ducation	16a. D	ecedent's Usual Occup	ation		16b. Kind of Busine	ess/Industry
Completed	(Specify only highest gr Elementary/Secondary (0-12)	a de completed) Coflege (1-4or 5		Give kind of work done o fe. DO NOT use retired	during most of workii d)	ng		
E O	12		' S	Salesman			Plumbin	3
Bec	17. Father's Name (First, Middle, Las.				18. Mother's Name			
ToE	John W. Faison S	c.			Martha 1	Branch .	rspei	
6 8	19a. Informant's Name/Relationship	(Type, Print)		Mailing Address (Street			-	e, Zip Code)
١.,	Jean Faison/wife		2	09 Hall Dr			21804	
	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [	Removal from State	20b. Place of D	isposition (Name of crematory or other plac CO Memorial	ce)		20c. Location - City	
1 8	4 □ Donation 5 □ Other (Speci		Park	co Memoriai	12/8	/05	Salisbur	y, MD
	21. Signature of Funeral Service Lie	ns e	2000	22. Name and Addres	ss of Facility	ome Prof	fessional	Association
	foell 1( A	crease (	+58	501 Snow I	Hill Rd.,	Salisbu	irv, MD 2]	1804
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do no	t enter the mode of dyin	ng, such as cardiac o	r respiratory arr	est,	Approximate Interval Between
	fmmediate Cause (Final disease or condition	Acyo	E M	V				Onset and Death
	resulting in death)	Due to (or as	a consequence of)	:				
	Sequentially list conditions.	b. ASW	10					YR 1
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	sonsequence of)					
Examiner	that initiated events resulting in death) Last	c.						
Ē		Due to (or as a	a consequence of)					
dical		_ d.						
Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				224 Date of	delivery
ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	′		23d. Date of Month	Day Year
ysic	9 Unknown	9□ Unknown	uno or dodin	J Cliff (specify)		- 9-5-24		
	Part fl. Other significant conditions	contributing to death bu	ut not resulting in t	he underlying cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
d by						1 🗆 Y	es 2 <mark>1</mark> 8€No 3□	Probably 4 Unknown
Completed						24a. Was a	n 24h Were	autopsy findings available
E G						autops	sy prior	to completion of cause of
	or Management and the section					1 ☐ Yes	2 No 1 1	fes 2□ No
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		ationt 3 DOA Oth	26. Place of Death			
2	27. Manner of leath	28a. Date of Injur (Month, Day		atient 3L DOA	4 🗆 Nursing Hor		ence 6 Other (S	Specify)
	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		<i>Year)</i> Inju	iry Wor	k? Yes 2 □ No		. ,	
	3 ☐ Suicide 6 ☐ Could not I	28e. Place of fnju	ıry - At home, farm	n, street, factory, office		28f. Location (S	treet and Number or	r Rural Route Number,
		building, etc	(Specify)	,		City or Town	n, State)	
	4 ☐ Homicide determined			1 1	ne, date and place, a	and due to the c	ause(s) and manner	r as stated.
Certification:	29a. Certifier 1 1 Certifying P	hysician: To the best of	of my knowledge,	death occurred at the tin			late and place and	
Certification:	29a. Certifier 1 1 Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination and/	or investigation, in my o	pinion, death occurre	ed at the time, d	ate and place, and	due to the cause(s)
	29a. Certifier 1 M Certifying P (Check only 2 Medical Exa	miner: On the basis of	examination and/	or investigation, in my o	pinion, death occurre	2	9d. Date signed (M	
Certification:	29a. Certifier 1 1 Certifying P (Check only 2 Medical Exa	miner: On the basis of	examination and/	or investigation, in my o	pinion, death occurre	2	9d. Date signed (M	
Certification:	29a. Certifier 1 1 Certifying P (Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and/	or investigation, in my o	pinion, death occurre	2	9d. Date signed (M	

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			State of Maryland / Department of Health and Me  1- For State Registrar  Certificate of Death	_	ene No. 0 0 5	41394
	Physici	an		2. Date of Death Month November	Day Year	3. Time of Death
	/Medic	al	the City Translation of Control	November	4c. County of Deatl	10:00P M
	Examin	er	Glade Valley Nursing & Rehab, Center Walkersville		Frede	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	9. Birth	pplace (State or Foreign
	Director		213-66-7401   1XI M 2   F   49   Yrs.   Months   Days   Hours   Min.	B. Date of Birth (Month, Day, Y Dec. 12,	, 1955 Pen	nsylvania
	and **		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryl f sho	rot				1 ☐ Yes 2 💆 No
	r 28a	irec	10e. Street and Number 10f. Zip Code	10g	g. Citizen of What Co	untry?
	th wit	Funeral Director	1321 Trevanion Rd. 21787		U.S.A.	
	er dea	nuei	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
36	irs after	by F	1 ☐ Yes 2 ☑ No  If Yes, Give  1 ☐ Yes 2 ☑ No  If Yes, Give  1 ☐ Yes 2 ☑ No  Specify:  Year or Dates:		Specify:	White
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exam or must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working		6b. Kind of Business/I	
21	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  Elementary/Secondary (0-12) College (1-4or 5+)  air conditioning mechan		commercial air condit	ioning
22	iled w Hygier ther ti	Col	17. Father's Name (First, Middle, Last)  18. Mother's Name (			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam not must be notified at ones.	To Be	Donot	hy Lawre		
ary	shou and M s mar tumat	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural I	Route Number, C	City or Town, State, Z	ip Code)
	and 2 salth a n 27 l		Debra A. Stambaugh/sister 13133 Good Intent Rd. L			
Baltimore,	ges 1 t of Ha if iter or oth		20a. Method of Disposition  1 Daurial 2 Cremation 3 Removal from State	1/.	oc. Location - City or	
Ē	it. Partimen ritant:		*4 □ Donation 5 □ Other (Specify)  21. Signature of Edineral Service Licenses		r. Tyrone,	
Ba	Depar Impor any ir		Catharine O. Hartler 6 E. Broadway Uni	on Bridg	ge, MD 217	91
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  A			months
	Examiner					
		iner	Sequentially list conditions, if any, leading to immediate cause. Either Undurfying.		72	
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Dise to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	icat Ex	resulting in death) Last Due to (or as a consequence of):			
687	ficate physis the					-
Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deli	very
	a deat he att	sicia	in the past 12 months?  1 Yes 2 No  9 Unknown		Month	Day Year
P.O.	res that the de signed by the a l be detached f			23e Did tobar	cco use contribute to	the cause of death?
ecords,	signe	d by		1 ☐ Yes		bably 4 Unknown
COL	w require been sign	Completed		24a. Was an	24b. Were aut	opsy findings available
$\mathbf{\alpha}$	The law ate has page 2 s	omp		autopsy performe 1 ☐ Yes 2	prior to c death? I No 1 ☐ Yes	ompletion of cause of 2□ No
Vital	ian: rtifica ctor, p	Be C	25. Was case referred to medical 26. Place of Death /		12103	20,10
of V	Physician: r this certific ral director,	ဥ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home		ce 6 □Other (Spec	ify)
on C	Jing P	:lon:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 Injury 3 Accident investigation 28b. Time of 28c. Injury at 28c. Injury Work? 3 Accident investigation M 1 Yes 2 No	3d. Describe how	injury occurred	
Division	Attending r death. sctor: After	ficat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28		et and Number or Rui	ral Route Number,
<u>S</u>	al or / s after N Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town, S	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (		id due to the caus	se(s) and manner as	stated.
	the P	Med			. Date signed (Month	
	F.₹ 5		D43091		12-1-05	
7	MIC		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Speed Zandi MN 801 This Itorse Ave		4	
	("		Speed Zaidi MN 801 Tou House Ave	. Fre	derick.	MO
	Sta					
	Registr	ar	DEO O D 2000 Boun S. Spark			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3:00 December 13, 2005 James Ottis Fields /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 28075 Old Village Road St. Mary's <u>Mechanicsville</u> Me Cira...

If Under 1 Year | If Under 1 Year | Hours Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F 79 Yrs Director May 29, 1926 Alabama 419-28-5468 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show rthen "natural, or Iteme 23a or 28e-f shov the Modical Examinar must be notified at 1 ☐ Yes 2 No St. Mary's Maryland Mechanicsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28075 Old Village Road 20659 U<u>S</u>A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baker Defense permit. Pages 1 and 2 should be tilt Department of Health and Mental Hy Importent: If Item 27 ie marked oth eny jinry or other traumatic event spag. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Frank Moody Fields Hester Bell Shirley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 94, Mechanicsville, Maryland 20659 Karen F. Mattingly / Daughter Baltimore, 20b. Place of Disposition (Name of competery, crematory or other place)
Tuscaloosa Memorial Date December 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Park 17, 2005 Tuscaloosa, Alabama 21. Signatur of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1 Enter the disease, or com shock or heart failure. List only compli Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** cance years una /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Physician/Medical Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. use as JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.0. sete has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ivision of Vital Records, Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2500 funeral director, 25. Was case referred to medical Be 26. Place of Death / Check only one examiner? Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō the Hospitel 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 13, 2005 00059061 ARATI PATEL, MD person who completed cause of death (Item 23a) (Type, Print) Prince Frederick Suite 212 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Biack indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** PATRICIA KATHERINE GRIFFIN 950 AM NOVEMBER 28 05 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL MD PRINCE GEORGE'S If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1□M XX F Yrs. Director 579**-**74-0650 50 6/12/55 WASHINGTON DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified a XX Yes 2□No Director or 28a-f PRINCE GEORGE'S CHEVERLY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with items 23a Funeral 2900 MERCY LANE 20785 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 0 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other tt any injury or other traumatic event, ITEM DAGE. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN MATTIE MAE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN MAE BROWN/SISTER 3300 C STREET #203 SE WASHINGTON DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 12/12/05 ALEXANDRIA, VA 21 Skr of Funeral Service Ligarise 22 Name and Address of Facility MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) · SEPSIS Days Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 2 TNo 3 Probably 4 Unknown multiple organita, lune 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? Diebetel Mellites Circhosis 2 No 11 I Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Baltimore, Maryland 21215-0020

Medical Certification: 29a. Certifier By

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Rd Myattswille MD 20781

NOVEMAER 28 ZOOS

State Registrar

LODE MD 4203 CHEEKSURE 32. Registrar's Signature 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 11:00 AM 06 Arthur Lee Hargrove 12 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges 6801 Bock Road, Unit 145 Fort Washington If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 06-03-40 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F NC 65 Director 239-66-1229 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1K Yes 2 □ No Director Fort Washington Prince Georges MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20744 6801 Bock Road, Unit 145 death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married or J Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private\_Industry Cement Finisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christine McCoy Claude Hargrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. 6801 Bock Road, Unit 145, Ft. Washington, MD 20744 Mary Hargrove/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Harmony Nat'l Park Landover, MD 12-10-05 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licensee | 6500 Allentown Road, Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Esophageal Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Mellitus, Type H 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Congestive Heart Failure 25. Was case referred to medical examiner? To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ů 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Director: After X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) guer 10 MD 4028079 Ranem 12-07-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francine A. Higgs-Shipman 11700 Beltsville Drive, Suite 100, Beltsville, MD 20704 31. Date filed (Month, Day, Year) State DEC 0 8 2005

Registrar

			For State Registrar	State of M	arylan		artmen rtificat				lental Hy	giene	105	1,1398
			Decedent's Name (First, Middle, La	st)							2. Date of D Month		Voor	3. Time of Death
	Physici /Medio		RONALD N	HARR	15						12	02	2005	1:55 PM
	Examir		4a. Facility Name (If not institution, giv	e street and number)	(u	MMC)	4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	h
			UNIVERSITY OF MARY	LAND MEDI			BA	LTIN	102E	, M				
	Funeral		5. Social Security Number 6. S	6ex 7. Ag		last birthday)	If Under Months	1 Year Days	It Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	av. Year)	Col	nplace (State or Foreign untry) DC
	Director		578-54-3737 Usual Residence of Decedent	J., 231	64	Yrs.					Dec. 1	6, 1940	)	DC
	and		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary	ō	Maryland Prince	Ceorge	For	ct Wasl	hinat	on						1 Yes 2 No
	the note	Director	10e. Street and Number	George	101	Lt Wasi	10f. Zip					10g. Citizen	ot What Coi	
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9	after or Ite		1 Never Married 2 Married	Armed Forces			1 ☐ Yes			i, Puerto	ricari, etc.)		Black, White	e, etc.
8	72 hours after death with the Maryland natural', or Items 23a or 28e-f ehow dical Executations be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			165	21/21/10	Specify.			Spe	Bla	ıck
5	be filed within 72 hours after death with the Marylan hat Hygiene. Id other than "natural", or Herns 23a or 28e-f show dvent, It a Medical Executar Indra be neilified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	kind of wo	rk done d	lurina most	t of work	ing	16b. Kind of	Business/I	ndustry
121	within ene.	m Id	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us					D .		
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and	ould be f Mental I arked of atic eve	Be c	William Harris							ira	Walk	,	anoj	
2	should by	오	19a. Informant's Name/Relationship (			19b Mailir	na Address	(Street a				er, City or Tov	vn State 7	in Code)
Maryland 21215-0036	id 2 sho lith and 27 ie mu traum		Ronald Harris, J				-					ington,		, ,
	s 1 and 2 should if Health and Men Itam 27 is marks other traumatic		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of	Ţ		Date	20c. Locatio		
J.	Pages nent of int: if it		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			emetery, crer acoln N				Dec.	9. 20	15 Suit	land	Maryland
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ä	Depa Impo any I		1 Mutte Ke	1000		4	Alexa: 5538 ]	nder Marl	S. P boro	ope Pike	Funera.	l Homes stville	P.A	20747
			23a. Part1. Enter the disease, or com shock, or heart tailure. List only	plications that cause	d the death								,	Approximate Interval Between
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	ecute and trans	Examine	that initiated events resulting in death) Last	c										
8760,	cate be executed obysician and the burial-transit			Due to (or as	a consequ	Jence of);								
87	death certificate be executed e attending physician and id for use as the burial-transii	Physician/Medical		d									-	
9 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv						224	2-1	
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal	death 3[	Ectopic pr Other (sp					100	Date of deliv Month	Day Year
o.	at the de by the a tached	isi	1 Yes 2 No 9 Unknown	9☐ Unknown			2 0 11 10 100	JUNY						
٥.	g g g	by PI	Part II. Other significant conditions of	ontributing to death b	out not resu	ulting in the un	nderlying c	ause give	n in Part I.		23e. Did	tobacco use co	ontribute to	the cause of death?
of Vital Records,	quires n sign uld be		SVC Syndrom	e							1 🗆	Yes 2□No	3 🗌 Pro	bably 4 dunknown
8	aw requir as been si 2 should	ojet									24a. Was	an 24	o. Were aut	opsy tindings available
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ita		Ф	25. Was case referred to medical						26. Place	of Death	Check only	2 No No one/	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	212110
<b>/</b>	S S	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Impatie	ent 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe	4 Nu	rsing Ho	me 5 ☐ Res	idence 6 🗆 C	ther (Speci	ıfy)
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9	part per the	ati	2 Accident investigation				М	ים ו	′es 2 □ l	No				
Division	or Attenation after deati	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory	, office				Street and Nui wn, State)	mber or Rui	ral Route Number,
	lospitel hours a unerel C	ဦ	00- 0	- 61										
	T 4 IT A	edical	29a. Certifier 1 Certifying Ph (Check only one) Medical Exar	ysician: To the best niner: On the basis o and manner st	f examinat	wledge, death ion and/or inv	occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the ed at the time,	date and plac	manner as : e, and due !	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	and marrier st	atou.		290	. License	number			29d. Date sign	ned (Month)	, Day, Year)
	r s r ŏ		1 adding	m m	ch-			ULLI	7643	SMII	763	17	2-1-	none
^	0		30. Name and address of person who	completed cause of	eath (Item	23a) (Type		V( 11	1 4 12	J			-/	,
	(3)			SOUTH G				P	ALTIN	nore	END	21201		
10 m	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	tűre	6.	Ų			1	00		
	Registr	ar	DEC 0 8 2005	Block	15	A CONTRACT								

			For 1 _ State	State of Maryland / I	Department of H Certificate of I		E.	. 000	41399
	_		Registrar  1. Decedent's Name (First, Middle,	Last)	Certificate of t		Reg. f		3. Time of Death
	Physici /Medic		Blackwell	T. Harris			Month 2	\$ 05	12:52PM
	Examin		4a. Facility Name (If not institution, of	rive street and number)	4b. City, Town, or	r Location of Death	2	County of Deat	h
-	Funeral		5. Social Security Number 6	Sex 7. Age (In yrs. last bit	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year 12-5-19)	9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent	19M 2LIF   48	Yrs.		12-5-191	06 111	2
	aryland phow	b-0	10a. State 10b. County	10c. City, Tow	m or Location	,			10d. Inside City Limits 1 Yes 2 □ No
	death with the Maryland ime 23s or 28e-f ehow ir must be notified at	recto	MD KENT  10e. Street and Number	Clus	101. Zip Code		10g. (	Citizen of What Co	
	th with	ai Di	27897 Mo	RGNECCutaff	Rd 216	20		USA	
	ter dea	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12 Was Decedent Ever in U.S. Armed Forces? 1  Yes Jano If Yes, Give	,	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
5-0036	hours after tural', or Ita	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify:	ack
15-0	in 72 h "natu fedica	Completed by Funeral Director	15. Decedent's (Specify only highest	grade completed)	. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of working	16b.	Kind of Business/	Industry
2121	filed within Hygiane. other than "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Constructi		E.	I Duk	WE
and	uid be file fental Hy rked oth tic event	Be	17. Father's Name (First, Middle, La	Harria		18. Mother's Name (	First, Middle, Maidle	en Sumame)	
Maryland	end N end N s ma	To	19a. Informant's Name/Relationship	(Type, Print) 19t	o. Mailing Address (Street	and Number or Rural I	Route Number, City	or Town, State, 2	Zip Code) 2/62/
	s 1 and 2 of Haaith Itam 27 other tr		//Largaut.	COOPER 20b. Place of	Toy / Norg	NEC Cut a	y Ka, Cal.	Location - City or	Town, State
mor	Pages lent of nt: If It ry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Hemoval from State	ry, crematory or other place	12-3-	15 CU	estector	OL, MD
Baltimore	permit. Pages Dapartment of Important: If I any injury or once.		21. Six ature of F neral Service Lie		The second of	ss of Facility	ne Rta	rton, Mb 298	ଅତୀଃ
			23a. Par 1. Enter the disease, or co shock, or heart failure. List or	implications that caused the death. Do	not enter the mode of dyin	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	a. Covovivy A  Due to (or as a consequence		eusl.			
ı	Examiner		Sequentially list conditions,	b.					
	ed sit	iner	many, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
ń	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	of):				
8760,	cate be physicial the but	dicai		d					
Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	2 Destania ara mana			23d. Date of del	ivery
O. B	requires that the death certificate be executeen signed by the attending physician and nould be deteched for use as the burial-trans	Completed by Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
, P.O.	quires that the de n signed by the a lid be deteched f	y Phy		s contributing to death but not resulting i	n the underlying cause giv	ren in Part I.	23e. Did tobacco	use contribute to	the cause of death?
spac	w requires been sign should be	d pa	Havinerd	Age			1 🗆 Yes	2 □No 3 □ Pr	obably 4 Unknown
3ecc	s b	mpie	Domenti	<u></u>			24a. Was an autopsy performed)	prior to d	topsy findings available completion of cause of
tal	The ate	a)	25. Was case referred to medical			26. Place of Death (	1 ☐ Yes 2 🗹 1		2 □ No
of Vi	nis di	To B	examiner?		utpatient 3 VOA Oth	4   Nuising Home			cify)
ouo	ding Phy th. After thi funeral	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	(Month, Day Year)	Time of 28c. Injury Work	yat k? Yes 2 □ No	d. Describe how in	jury occurred	
Division of Vital Records,	or Atter after dea Director in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		arm, street, factory, office	28	f. Location (Street City or Town, Sta	and Number or Ru ate)	iral Route Number,
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerei Director: After ti completely filled in by the funera	Medical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge aminer: On the basis of examination are and manner stated.	e, death occurred at the tin nd/or investigation, in my o	me, date and place, an opinion, death occurred	d due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the complé	Me	29b. Signature and little of certifiet/	and -	29c. Licens	e number	29d. [	Date signed (Month	h, Day, Year)
	, .		and	ma -	1000	58824		11/36/0	<
	(1)5	- 1	30 Name and address of person with	no completed cause of death (Item 23a)	(Type, Print)	Galon	a MO	21635	
\$	Sta		31. Date filed (Month, Oay, Year)	32. Registrar's Signature					
	Registr	ar	NOV 3 0 7	005	March 1				

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State of N		artment of Health and N rtificate of Death	Reg	/ 11115	1400
	Physici		Decedent's Name (First, Middle, Last)			2. Date of Death Month Dec. 2,	Pay 2005	3:05 p M
	/Medic	al	William Hermon Hopkins  la. Facility Name (If not institution, give street and number	ar)	4b. City, Town, or Location of Death		4c. County of Death	
1	Examin	er	Mallard Bay Care Center	.,,	Cambridge		Dorches	ster
	Funeral Director		5. Social Security Number 6. Sex 7. 220–12–0720	Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, You Dec. 9.	9. Birth Cou 1923 Ma	place (State or Foreign ntry) ryland
	0		Jsual Residence of Decedent					10d. Inside City Limits
V	Maryland I-f ehow	5	Marvland Dorchester	10c. City, Town or Lo	rch Creek			1 □Yes 2 ☑ No
X	28a-1	recto	Maryland Dorchester  10e. Street and Number	Gridi	10f. Zip Code	10g	. Citizen of What Cou	intry?
2	death with the rms 23s or 28s	Funeral Director	3209 Bayview Drive		21622		US	A
0	deati	nera	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
36	be filed within 72 hours after death with the Marylan Hygiene. Id other than "natural", or itema 23a or 28a-1 show event, I're Medical Examinar mast be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	□No	1 ☐ Yes 2 ☐ No Specify:		Specify:	
21215-0036	tural'	ed b	15. Decedent's Education	16a, Dece	dent's Usual Occupation	16	b. Kind of Business/li	ite ndustry
215	within 72 ene. than "na	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	or 5+)	kind of work done during most of wor DO NDT use retired)			
21	ed wit ygjen ner th	Completed	12 4	Paro.	le Officer		state Gove	rnment
and	ntal H	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	iden Sumame)	
Maryland	s 1 and 2 should be tiled within Health and Mental Hygiene. Item 27 Ia marked other than other traumatic event, I'm Mi	2	William Hermon Hopkins  19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Ru	e Russell ral Route Number, C	City or Town, State, Z	ip Code)
Ma	alth ar 27 in 27 in or trau		Martha H. Allen/Daughter	3209	Bayview Dr., Chur	rch Creek.	MD 2162	2
Baltimore,	es 1 and 2 of Health of Itam 27 i		20a. Method of Disposition  1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from Sta	20b. Place of Dispe cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or T	own, State
<u>Ë</u>	Pag ment tant: i	Ι.,	* 4 ☐ Donation 5 ☐ Other (Specify)	MD Vetera			Hurlock, M	D
Ball	permit. Pages Department of I important: If its any injury or of once.		Signature of Fineral Service Licensee	vell 3	2. Name and Address of Facility Surran-Bromwell Fu 808 High St., Camb	meral Hom oridge, MD	P.A. 21613	
			29a. Part1. Enterthe disease, or complications that cau shock, or hear failure. List only one cause on each	sed the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ng cano	er			5yeas
	Examiner		Due to (or	as a consequence of):				
		Jer	Sequentially list conditions, if any, teating to fine added cause. Enter Underlying Cause (Disease or injury	as a consequence of:				
	ecuted ind transit	Examiner	that initiated events					
8760,	ite be executed lysicien and ne buriai-transit		Due to (or	as a consequence of):				
687	tificate g phys as the	edicai	d					
Вох	eath certifi attending   for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco		Ectopic pregnancy		23d. Date of deliv	
Ю.	the the	Physician/Med	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  4 ☐ Pregnan 9 ☐ Unknown	t at time of death 5	Other (specify)		Month	Day Year
<u>ر.</u>	es that the gned by be detact	by Ph	Part II. Other significant conditions contributing to deat	h but not resulting in the o	inderlying cause given in Part I.		cco use contribute to	
rds	w requires been sign should be					1 ☑ Yes	2 No 3 Pro	obably 4 Unknown
Records,	e law re has be je 2 sho	Completed				24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
	iician: The l certificate ha rector, page		25. Was case referred to medical		26. Place of Dea	1 Yes 2 th (Check only one)	No 1 L Yes	2 No
Ž	ysician: is certific director.	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inp	atient 2 ☐ ER/Outpatie	Other		ce 6 □Other (Spec	erfy)
n of	ding Ph I. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month,	njury 28b. Time ( Day Year) Injury	Work?	28d. Describe how	injury occurred	
Division	Attending Physician: r death. sctor: After this certificator, is the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be	Injury - At home, farm, si	M 1 Yes 2 No	28f. Location (Stre	et and Number or Ru	ral Route Number.
Div	at or At s after of it Direct of in by	Certification;	4 Homicide determined 289. Place of building	, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one) 12 Certifying Physician: To the be 2 Medical Examinar: On the bas and manne	s of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occu	and due to the cau arred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Month	Day, Year)
			Deparson or	)	4005997	3 /	2/5/0	3
			30 Name and address of person who completed cause 12 triciz Johnson	of death (Item 23a) (Type	.Print) amble Street,	Cambrio	dge, M	0
4	St Regist	ate rar	29b. Signature and title of certifier  Application of person who completed cause of the complete cause of the cause of the complete	Mar's Signature	Sperke			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month <sup>Day</sup> **Physician** 2005 Eleanor Valina Hoffman December 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SunBridge Care & Rehabilitation E1kton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. October 24, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 4, 1917 1 M 2 F Director 215-09-8398 88 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or iteme 23e or 28e-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Cecil Maryland Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21921 1 Price Drive United States of America Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify **X**☐ Widowed 4 ☐ Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Roland John Tucker Margaret Ellen Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itsm 27 Is 503 Highland Drive, Elkton, Maryland 21921 Edward V. Hoffman Son other 20b. Place of Disposition (Name of cemetery, crematory or other Page)r k 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 permit. Page Department ( Important: If any injury or once. Woodlawn Memorial 12/16/2005 Easton, Maryland <sup>22</sup> Name and Address of Facility Home, P.A. 21. Signature of Funeral Service Licens South Second Street, Denton, MD 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TKRUE ME disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 220B176 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1□ Yes → No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 3a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After. Injury 1\_Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could nov e 3 Suicide 2.e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Lectifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 817 CHURCHMANS FRLEH MD NEWGODE DE 19720 31. Date filed (Month, Day Year) 32. Registrar's Signature State DEALER Registrar

			1- State of Maryland	Depa Cer	artment of Health ar		giefie	5 4	1402
r			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath		3. Time of Death
7	Physic /Medi		Olie Wood Harvey			Decembe	er 15.	Year 2005	8:25 P <sup>M</sup>
)	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of I		4c. Count		
			St. Mary's Nursing Center		Leonardtown			Mary's	
Ĉ	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 X F 92	Yrs.	If Under 1 Year If Under 24  Months Days Hours	Min. (Month, Da)	y, Year)	Countr	ce (State or Foreign y)
w.	- A		Usual Residence of Decedent			September	22,1913	Maryl	and
	rylan how		10a. State 10b. County 10c. City, To	own or Lo	cation			100	d. Inside City Limits
	e Ma	cto	Maryland St. Mary's Leona	ardto	wn				1 ☐ Yes 2 X No
	ith th	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of	What Countr	y?
	ath v		22650 Cedar Lane Apt. 1308		20650		USA		
9	a within 72 hours after death with the Maryland Jione rithan "natural", or itema 23a or 28a-f show the Marical Examiner must be notified at the Marical Examiner.	/ Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes, Give	li li	Vas Decedent of Hispanic Origin i Yes, specify Cuban, Mexican, F ☐ Yes 2♥ No Specify:	i? (Specify Yes or No- Puerto Rican, etc.)	Bla	ce - Americar ck, White, et	
Maryland 21215-0036	ural',	d by	3 X Widowed 4 □ Divorced Year or Dates:				Specif	Whit	:e
15-	72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most or PO NOT use retired)	f working	16b. Kind of B	usiness/Indu	stry
12	within 72 iene. than "nay	шс	Elementary/Secondary (0-12) College (1-4or 5+)		e Clerk		Cleric	0.1	
b	e filed within al Hygiene. I other than vent, the Ma	BeC	17. Father's Name (First, Middle, Last)	TITC		Name (First, Middle,			
au	should be nd Mental marked c	To B	William Leonard Wood		Mary M	Melvina Woo	nd		
ary	2 should and Men ie marke aumatic	-	19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	g Address (Street and Number of			State, Zip C	ode)
	12 m		William Archie Pilkerton / Nephew 26	5400 N	orth Sandgates Roa	d, Mechanics	ville, Ma	ryland	20659
altimore,	jes 1 av of Hea if item or othe		20a. Method of Disposition 20b. Place 20b. Place ceme 20b. Place	of Dispos itery, crem	sition (Name of patory or other place)	Date December	20c. Location	City or Town	n, State
Ë	Pag Iment tant: jury o		4 Donation 5 Other (Specify) Spring	; Hill	Cemetery 1		Lynchbur	. Vir i	nia
Ba	permit. Pages Department of the Important: if ite any injury or of		21 Significe of Funeral Service Ligense		Name and Address of Facility ttingley-Gardiner O. Box 270, Leonar	Funeral Home dtown, Maryla	P.A. and 20650		
in a second	<b>%</b> -		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dying, such as car	rdiac or respiratory arr		A	pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition CAO 310	mI	310 81CB				nset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence	e of):					
	LAGIMINET	l <sub>m</sub>	Sequentially list conditions, b. 17 y Po Hyn.	_ريد	Hypen 4.0i	em,	Anen	קיני	
	bel list	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	e of):					
	al-tra	хаг	that initiated events resulting in death) Last C	e of):					
8760,	cate be executed physicien and the burial-transit	dicai E	C <sub>d</sub>						
9			<u> </u>						
Box	that the death certifined by the attending to detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	ıth 3□	Ectopic pregnancy		23d. Da	e of delivery	
о. О	ed for	sicie	1 Yes 2 No 4 Pregnant at time of death		Other (specify)		Mo	nth Da	ay Year
<u>Ч</u>	at the	Phy	9 U ONKNOWN						
	es pe	þ	Part II. Dther significant conditions contributing to death but not resulting	in the un	derlying cause given in Part I.				cause of death?
Ö	w requir been s should	Completed	100	9		_ 1 \ Y	es 2 No	3 Probab	ly 4 Unknown
Vital Records,	e law hes t	прi	· Anemia H · UI BI	eev.	~	24a. Was a autops	y F	prior to comp	y findings available letion of cause of
<u></u>			. Decul weg'			perform 1 ☐ Yes		death?	□No
	Phyaician: this certific ral director.	Be	25. Was case referred to medicat examiner?		Othor	Death (Check only on			
ō	Phys or this sral di	. To	1 Inpatient 2 ER/C	Outpatient  Time of	3LI DOA 4 AVINUISII	ng Home 5 Reside			
o	Attending in death.	atlor	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. 2000/120 110	ow injury occur	60	
Division	Atternation of the part of the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm, stre	et, factory, office	28f. Location (St	reet and Numb	er or Rural R	oute Number,
	talor s afte al Din ed in l	Cert	4 Homicide building, etc. (Specify)			City or Town	n, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death and/or invi	occurred at the time, date and plestigation, in my opinion, death of	lace, and due to the coccurred at the time, d	ause(s) and ma ate and place, a	nner as state and due to th	ed. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	2	9d. Date signed	(Month, Day	y, Year)
)			· ~		D0062213		12 16	5	
			30. Name and address of person who completed cause of death (Item 23a	) (Type, F	rint)			1	
	200		Suresh H. Patel, M.D. 22650 Cedar Lane C	ourt,	Leonardtown, Maryl	and 20650			
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 16 2005  32. Sgistrar's Signature	1	and .				
36 g	- Incalon	सा	TIEL I O COUJ ARTENIO						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 3 2005 Larine Hutton 1919 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 5 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 212-30-6527 1 ☐ M 2 🛛 F 70 Yrs. 7835 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ehow the Medical Exeminer must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Garden Gate Lane 21403 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** þ Specify: 3X Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Housewife 0 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even George W. Turner Louise H. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Downs(Daughter) 203 Garden Gate Lane Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Maryland Veteran 12-8-05 4 □ Donation 5 □ Other (Specify) Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 214 Lavry B, Reese M004 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Muxocordia **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year 4□Pregnant at time of death Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown ohs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed 2 No within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 X ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 Tyes 2 No 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge daith crumed at the line, date and place, and due to the eauso(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48101 12-5-2005 Vonice 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Pkuy Suith 350 Annapolis MD2401 2002 hambes MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 0 7 2005** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			State of Maryland				1ental Hyg	iene		1101
2	<b>*</b> **		Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	eath eath	2. Date of Deat	eg. No. U	0	+ 1404
	Physici		0 A . / A	-			Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	11	4b. City, Town, or	Location of Death	12_	4c. County	of Death	3 P"
		Šv.	· University on Mayimus MEDICAL CENT	EK	BACTIM			,		
14	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul. 13	Year)	9. Birthpla	ace (State or Foreign
*	Director		214-88-6713 10XM 2 F 40 Usual Residence of Decedent	Yrs.			Jul. 13	, 1965	- COUNT	MD
	yland sow			, Town or Loc	ation				10	d. Inside City Limits
	B-f sh	tor	MD Anne Arundel		Glen Bu	rnie				1 ☐ Yes 2 🔯 No
	ith the	Dire	10e. Street and Number		10f. Zip Code		10	Og. Citizen of V	Vhat Countr	y?
	s 23a	Funeral Director	7849 Crilley Road, Apt. 504	,	2106	51			USA	
	Item	une	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  12. Never Married 2 ☐ Married  11. Was Decedent Ever in U.S Armed Forces?  11. Yes 2 № No		as Decedent of His Yes, specify Cubar	spanic Origin? (Spe i, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, et	
5-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show rdical Examinat must be molitied at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	11	☐ Yes 2🔀 No	Specify:		Specify	: Wh	ite
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2121	2 12	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. Di	ind of work done du O NOT use retired)		ng			
	lled Tygi ther nt, t		17. Father's Name (First, Middle, Last)	In	dependent			Ar		
Maryland		o Be	Raymond Earl Holland, Jr.			18. Mother's Name			θ)	
ary.	2 should and Men is marke	ř	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street ar		Curtessi		State Zin C	Padal
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Angela Rogers/Mother		t. Bees [				2114	
ore			20a. Method of Disposition 20b. Place 1 (2XBurial 2 Cremation 3 Removal from State	ace of Disposi	ition (Name of atory or other place	Г		Oc. Location -		
E m	Pages ment of tant: If it		4 Donation 5 Other (Specify)		s Cemeter	Zy 20		Baltir	more,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Puneral Service Uconsee	Ba	Name and Address rranco & 5 Gov. Ri	Sons, P.	A. Sever	na Parl	s Fune	eral Home
Figs			232 Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	1 -5	2 00 v . Ita	CCITTE IIM	A' DE AET	na ran		ZII40 Approximate
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	nsit	Examiner	cause. Enter Underlying							
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			IF FEMALE:							
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	law requires that the de as been signed by the 2 should be detached	y Pt	Part II. Other significant conditions contributing to death but not result	ting in the und	erlying cause given	in Part I.	23e. Did toba	acco use contri	bute to the	cause of death?
Division of Vital Records,	quire en sig ruld b	Completed by	RENAL TAINS PLANTATION, C	monic	Reine	INSUFFICIENCE	1 □ Yes	2 □ No	3 Probab	ly 4 Munknown
eco	as 2	plet	HYPERTENSION, HEPATITIS B	3. Circa	RHOSIS		24a. Was an	24b. W	ere autopsy	y findings available
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of	Phys. this cral dir	٦.		P/Outpatient	3□ DOA Other:	4   Nursing Hom				
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	ledge, death o	ccurred at the time, stigation, in my opin	date and place, a	nd due to the cau d at the time, dat	se(s) and man e and place, ar	ner as state	ed.
	other other	Me	29b. Signature and little of certifier		29c. License n			I. Date signed		
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			30. Name and address of person who completed cause of death (Item 2	23a) (Type, Pri		-		1-1/		
			ABRAMAM LIN, UNIVERSIT		Marvey	AND				
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signatu	re M	Could .					
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	Physic	ian	Decedent's Name (First, Midd	le, Last)			مالنا				2. Date of Death Month	Day .	Year	3. Time of	Death
	/Med	cal	JERRY	<u> </u>				Woo			DECEMBER	6	20005	08:46	AM
	Exami	ner	4a. Fecility Name (If not institution		PITAL				Location				nty of Death		
-	Funeral		THE JUHNS HOP		7. Age (In yrs.	last birthday)			If Under		8 Date of Righ		timore		
	Director		426-84-0841 Usuel Residence of Decedent	1 <b>X</b> M 2□F	62		Months	Days	Hours	Min.	8. Date of Birth (Month, Day,) 3-4-1943	Year)	Hatt	olace (State of itry) iesbur	g, M
	uylan show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						1	0d. Inside Cit	y Limits
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	with the	D.	10e. Street and Number				10f. Zip	Code			100	g. Citizen d	f What Coun	itry?	
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Baltimore, Maryland 21215-0036	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relations Alice Hegwood								Al Route Number, C Millsbor				
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation	3 DRamoval from S	20b. F	Place of Dispo cemetery, cred De Hen I	sition (Nam	e of her place	, 1	C	ate 20	c. Location	- City or To	wn, State	
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical I	and manne	is of examinat	tion and/or inve	astigation, if	n my opir	nion, death	occurre	d at the time, date	and place,	and due to the	he cause(s)	
	⊢ 3 <del> </del> 3		11101	15						-100			d (Month, Da		
	1	-	30. Name and address of person	who completed cause	of death /Item	23a) (Type P		rc2.	- 00	0	DEC	EMBER	- G,	2005	
	4.7			- 12 A		LTH WOLL	_	LEET	Ra	LTIM	OPE, MAR	16611		707	
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			1- For State of Maryland / Dep Registrar C6	artment of Health and artificate of Death	Mental Hygie	21115 1.11.00			
	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, Last) George Ross Hartman		2. Date of Death December	3. Time of Deat 1:50 P.			
	Examir		4a. Facility Name (If not institution, give street and number) National Lutheran Home	4b. City, Town, or Location of Dea Rockville	th	4c. County of Death Montgomery			
	Funeral Director	П	5. Social Security Number $202-09-5250$ 6. Sex $1\square 3M$ $2\square F$ 7. Age (In yrs. last birthday 86 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min					
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L Maryland Montgomery Rockvill			10d. Inside City Lim 11∕2 Yes 2 □	iits		
	h with the	Funeral Director	10e. Street and Number 9701 Veirs Drive	10f. Zip Code 20850		10g. Citizen of What Country? United States			
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural', or Iteme 23e or 28e-f show among highly or other traumatic event, the Medical Examinate must be notified at anone.	b	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give WW II Year or Dates:	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
3500-6171	within 72 holene. Than "nature the Medical E	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation is kind of work done during most of wo DO NOT use retired) DETVISOT	rking	Kind of Business/Industry			
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, mary	and 2 should lith and			ng Address (Street and Number or A Veirs Drive, Roo					
Банттоге,	Pages 1 g ment of He ant: If item ury or othe			Center 2	ember 4 005 Wa	Location - City or Town, State			
סמונ	permit. Departr Importa any init		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Co		tuary Services, In D.C. 20037	nc.		
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,00700	ficate be executed physiclen and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):						
.C. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death:  To the Functal Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
COLOS, T	quires that in signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the L	inderlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death?	٧n		
חמפת וו	The law re ate has bee page 2 sho	Completed	Dycohasia		24a. Was an autopsy performed?		ole f		
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2	tal or Atters setter des	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)			
	he Hospi in 24 hou he Funer pletely fill	edicai	29a. Certifier (Check only one)  1] **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.						
	Som Com	2	29b. Signature and title-of certifier  Multi-line	29c. License number  D 00 506/2		ember 4, 2005			
	•		30. Name and address of person who completed cause of death (Item 23a) (Type,	9701 Veirs Drive		,			
	Sta Registr	3	31. Date filed (Month, Day, Year)  32. Registrar's Signature	nde					

Amend item#3, perMD, G851, 1/5/06 TT State of Maryland / Department of Health and Mental Hygiere 0 0 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day **JOHNSON** MOSES DECEMBER 2005 10:15 +/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**反**M 2□ F 579-16-2011 Director 91 1914 SOUTH, CAROLINA 10 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow 10d, Inside City Limits r than "natural", or Items 23a or 28a-f ehov the Medical Examinar mant be motified at 1X Yes 2 No Directo PRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6510 INSEY STREET 20747 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT DRIVER 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event 8008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be .TACK JOHNSON ANNA MONROE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRETT/NIECE 6510 INSEY STREET FORESTVILLE, MARYLAND REGINA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 12/9/2005 SUITLAND, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dowe /Medical Que to (or as a consequence of): Examiner ria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 500 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has autopsy performed certificate 1 Yes 2 No : After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 XNo 1 Sepatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural Certification: 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. I Director: And in by the f М 2 Accident investigation 1 Tyes 2 □ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier 29b. Signature and title of Cartifie 29c. License number 29d. Date signed (Month, Day, Year) 3 100 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 31. Date filed (Month, Day, Year) State DEC 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 26, 2005 Year **Physician** 11:45 A. M Florence M. Jennings /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 3, 1907) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** 1 M 2 XF North Carolina Yrs. Director 219-20-7451 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23s or 28e-f show the Medical Everther must be notified at Fort Washington 1 XYes 2 No Prince George's Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 U.S.A. 12113 Domybrook Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Donestic Engineer 12th grade permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other than any injury or other traumatic event, Tagones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Strong Eddie Lee Strong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
713 Harry S. Truman Drive Largo, Maryland 20774 19a. Informant's Name/Relationship (Type, Print) Mr. Palmer A. King 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Crematory, Inc. November 30,2005 Beltsville, Maryland Rollins Fireral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to rheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATTERS Schools Cardio vashla **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 045365 11-28-2015 Civings for ad KIII, ft washington Ma 20784 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidaneul, on. 0 11701 Michael 31. Date filed (Month, Day, Year) . Registrar's Signature State DEC 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

State   The County   Prince Georges   10c. City, Town or Location   Upper Marlboro   10d. Zip Code   10d. Zip Code   10d. Zip Code   10d. Zip Code   13d. Marlad Status   11d. Marital Status   11d.	PRINCE GI  Vear)  19. Birth Cot  19.	EORGE Shipplace (State or Foreignate) shoma  10d. Inside City Limit  18 Yes 2 N  untry?  incan Indian, ,, etc.  1ack  industry  ent  ip Code) D 20774
13614 NEW ACADIA LANE	PRINCE GI 9. Birth Cot 1948 Okla  G. Citizen of What Cot USA  14. Race - Ameri Black, White Specify: Bi 6b. Kind of Business/Ir  Governmentation Sumame)  Significant City or Town, State, Zin Cot, Location - City or Town	EORGE Shipplace (State or Foreignate) shoma  10d. Inside City Limit  18 Yes 2 N  untry?  incan Indian, ,, etc.  1ack  industry  ent  ip Code) D 20774
Value   Part   Value	g. Citizen of What Cou  USA  14. Race - Ameri Black, White Specify: B.  Sb. Kind of Business/Ir  Government Siden Surname)  Scity or Town, State, Zin  arlboro, Mi Ic. Location - City or Town	hplace (State or Foreignity) alhoma  10d. Inside City Limit  1  Yes 2  N  untry?  rican Indian, a, etc.  1  ack  ndustry  ent  ip Code)  D 20774
10e. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10c. Street and Number   10c. Street and Number   13614 New Acadia Lane   10c. Street and Number   10c. Street   10c. Stre	g. Citizen of What Cou  USA  14. Race - Amer Black, White Specify: B.  Sb. Kind of Business/Ir  Government diden Surname)  Scity or Town, State, Zin  arlboro, M.  Ic. Location - City or Town	1  Yes 2 □ N  untry?  rican Indian, a, etc.  1 ack  ndustry  ent  ip Code)  D 20774
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mary 19   19. Mailing Address (Street and Number or Rural Route Number, C   13614 New Acadia Lane, Upper Mary 19.	USA  14. Race - Ameri Black, White Specify: B.  Sb. Kind of Business/Ir  Governmentiden Surname)  Signature City or Town, State, Zing arlboro, M.  Ic. Location - City or Town	rican Indian, a, etc.  1ack  Industry  ent  ip Code)  D 20774
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mary Name)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (N	Black, White Specify: B. Sb. Kind of Business/Ir Government and an Amame)  Scity or Town, State, Zinarlboro, M. Sc. Location - City or T.	ndustry  ent  ip Code)  D 20774
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mary Name)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (Name of Commetery, crematory or other place)   19b. Mariling Address (Street and Number or Paral Route Number, Condition (N	Government (Grand Control of Cont	ent ip Code) D 20774
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mary 19   19. Mailing Address (Street and Number or Rural Route Number, C   13614 New Acadia Lane, Upper Mary 19.	aiden Surname)  Sity or Town, State, Zij  Brlboro, Mi  c. Location - City or T	ip Code) D 20774
1	City or Town, State, Zince Thoro, Mile. Location - City or To	D 20774
Committee   Comm	ar1boro, Mic. Location - City or T	D 20774
1 Serial 2 Cremation 3 Removal from State   1 Serial 2 Commettery   12/13/2005   MD. Veterans Cemetery   12/13/2005   C   22. Name and Address of Facility J.B. Jenkin   7474 Landover Rd., Landover,   23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Immediate Cause (Final disease or condition resulting in death)   Sequentially list conditions,   25	c. Location - City or T	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician   Medical   Examiner   Medical   Examiner		,
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician / Medical Examiner  Sequentially list conditions, cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death)  Due to (or as a consequence of):  CREUTZFELDT—JAKOB DISEASE  Due to (or as a consequence of):	heltenham, s Funeral	Home
Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause (Final death)   Immediate Cause		Approximate
Sequentially list conditions, If y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    CREUTZFELDT-JAKOB DISEASE		Interval Between Onset and Death
That initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
23c. If yes, outcome of pregnancy  23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy	\	
23b. Was decedent pregnant  1 Live birth 2 Felal death 3 Ectopic pregnancy  1 Pregnant to time of death		***
으로 두분 <mark>%</mark> 9□Unknown 9□Unknown	23d. Date of delive Month	ery Day Year
	co use contribute to the	_
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4 Substitute determined 28e. Place of Injury: At home, farm, street, factory, office 28f. Location (Street	t and Number or Rura tate)	al Route Number,
29a. Certifier (Check only one)  We Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause control of the cause control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause control of the cause control	e(s) and manner as st and place, and due to	tated. o the cause(s)
29d. (Cleanse number 29d. (	Date signed (Month, I	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CEMBER 7,	2005
MITCHELL T. WALLIN, MD, 50 IRVING STREET, WASHINGTON, DC 20422/68  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	38	

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 6, 2005 GENEVA JENKINS JONES 1:22 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RESIDENCE. 900 WASHINGTON AVENUE LA PLATA CHARLES 8. Date of Birth
Month, Day, Year) 23 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Months Days Hours MARYLAND 218-24-0314 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Madical Examinar must be multilad at 1 TyYes 2 □ No Directo MARYLAND CHARLES LA PLATA 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 900 WASHINGTON AVENUE 20646 UNITED STATES death Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Illinportant: If item 27 is marked other than "naturel", or iter any injury or other traumatic event, the Medical Exemplane. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE HOUSEWIFE HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN JENKINS KATIE WILLS JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS W. JONES / HUSBAND 900 WASHINGTON AVENUE, LA PLATA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ST. IGNATIUS CHURCH CEM. DEC. 12, 2005 CHAPEL POINT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Special of Funda Service Laboration Service Laboration Service Laboration JOHNSON MO0583 THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) month /Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ģ Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 25 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)
Injury at 28d. escribe how injury occurred 2 this 27. Manner of Pear Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After To the Hospital or Attending Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c: License number 29d. Date signed (Month, Day, Year) 46246 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ASHRAF MEELU, M.D., #10 ST PATRICKS DRIVE, SUITE 408, WALDORF, MARYLAND 31. Date filed (Month, Day, Year) DEC 0 8 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2005 Peter David Jobeck Dec. 3:35 a ™ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Trappe

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 30276 Chestnut Ridge Lane Talbot 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year Sept. 10, Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Director 165-28-4881 69 1936Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Items 23e or 28a-f show 10d. Inside City Limits Director 1 Yes 2 No Maryland Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23e any injury or other treumatic event, the Mydical Examiner must anone. 30276 Chestnut Ridge Lane 21673 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Des 2 No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Pharmaceutical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John James Jobeck Dorothy Markley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel I. Jobeck/Spouse 30276 Chestnut Ridge Lane, Trappe, MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCenter12/8/2005 Cambridge, Maryland **Physician** /Medical **Examiner** To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

in by the funeral after death within 24 hours a completely filled

X	The flee Military	22. Name and Address of Facility Mid Shore Cremation 2772 Hudson Rd Can	Center, P.O. Box 1464, mbridge, MD 21613
	23a Part1. Enter the disease, or comp shock, or heart ailure. List only Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of):  c. — Due to (or as a consequence of):  d. —	
hysician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery  Month Day Year
ompleted by F	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
BeC	25. Was case referred to medical	26. Place of Death (C	1 Yes 2 No
0	examiner? 1 🗌 Yes 2 🗹 No	Hospital:	5 Presidence 6 □Other (Specify)
catlon:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  M 1 Yes 2 No	d. Describe how injury occurred
Medical Certification: T	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	. Location (Street and Number or Rural Route Number, City or Town, State)
edical	one)	/sician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
Σ	29b. Signature and fittle of certifier	SWW D39681	29d. Date signed (Month, Day, Year)

dsmith, mp. 29466 Pinkil Drive Suite 5, Easton, mo 21601

State ·Registrar

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			1 - For State Registrar	State of Mary	land / Depa	artment <i>rtificate</i>	of H	ealth a	and M		giene Reg. No.	) 0 5	5	1, 11,	12
	S -30		1. Decedent's Name (First, Middle, Las	it)						Date of Dea     Month	ath Day	,	Year	3. Time of	Death
	Physici /Medio		Barbara Blanch	e Johnson						Decembe		200		5:15	рм
ì	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of	of Death		4c. C	County o	I Death		
7.0	* **	KĒ.	9509 Mazzoni Ave			Seal								George'	
	Funeral		5. Social Security Number 6. S	DM 2KTE	yrs. last birthday)	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day	y, Year)		COL	place (State on intry)	
×	Director		577-44-3332 Supplies the State of December 1	7	'3 Yrs.					Feb. 2,	, 193	2 1	Wash	ningtor	ı, DC
	and w		10a. State 10b. County	10	c. City, Town or Lo	ocation								10d. Inside C	ity Limits
	f sho	ō	Maryland Prince	George's	Seabroo	ŀ								1 🗌 Y <i>e</i> s	2 🛚 No
	158 - 288 - 158 -	Director	10e. Street and Number	Jeorge S	Seaproo	10f. Zip (	Code				10g. Citiz	en of W	hat Cou	intry?	
	3a or	0	9509 Mazzoni Ave	nue		207	706				U	JSA			
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show diest Examinal must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decede	nt of Hi	spanic Ori	gin? (Sp	ecify Yes or No-		4. Race		ican Indian,	
ယ္	after or he	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No		If Yes, specif	•		i, Puerto	Hican, etc.)			White		
03	al', o	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	LIKNO	Specify:			3	Specify:	wnı	ce	
21215-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual	Occupa	ition <i>urina</i> mos	t of work	na	16b. Kin	d ol Bus	iness/l	ndustry	
21	within ene. then "	nple	Elementary/Secondary (0-12)	Cotlege (1-4 or 5+)	life.	DO NOT use	retired)	)							
21	ygier ygier t, tr	S	12		Admin	istrat								ernmer	it
pu	d oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden S	iumame	)		
<u>yla</u>	should be filed within and Mental Hygiene. s marked other than "numatic avent, I'm Men	٩	James E. Dawn						Ls Ce						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic avent, it a Miscless Examination in a logified at a contract of the con		19a. Informant's Name/Relationship (	Гуре, Print)	19b. Maili	ng Address (	Street a	nd Numbe	er or Run	al Route Numbe	r, City or	Town, S	itate, Zi	ip Code)	
-	of Health of Hea		Christian A. John		9309 Ob. Place of Dispo			ant I		Laure]					
0	Pages 1 nent of H. ant: If Ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removat from State	cem <i>etery</i> , cre	matory or oth	er place		Decer	nber 7,	20c. Loc	ation - C	lity or I	own, State	
Baltimore,			4 □Donation 5 □ Other (Specifi		MD Veteran									Mary]	.and
3ali	permit. Departr Imports any inj		21. Signature of Funeral Service Lices	(\$ee						Funeral					
	Q □ = 0		Koleert / f	Spr						1. W, Si		Spi	ring		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		death. Do not en	ter the mode	ol dying	, such as	cardiac	or respiratory ar	rest,			Approximate Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition	a_Metastati	c Lung C	ancer								5 Year	
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):										
3%	LAdminer	_	Sequentially list conditions,	b											
	pe tis	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence oi):										
	death certificate be executed e attending physicien and of for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	nsequence of):										
8760,	be ed icien buria				,										
87	phys the	d		d							·		-		
9 X	death certifica attending ph d for use as th	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pr	regnancy						2,	3d. Date	of deli	(80)	
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					2.	Mont			Year
o.	the d	ysk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	3 31 332	_ 0 (110) ( <b>3</b> 00	On 17								
0	law requires thet the de es been signed by the a 2 should be detached f		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	ınderiying ca	use give	n in Part I		23e. Did to	obacco us	e contrit	oute to	the cause of o	leath?
ds	ures sign ld be	d by								1 🔼 Y	/es 2 □	No 3	B 🗆 Pro	bably 4 🗍	Jnknown
Records,	w require been si should I	Completed								24a. Was	20	245 W	ere aut	opsy lindings	available
Re	0 5 0	Ę								autop		pri	or to coath?	ompletion of a	ause of
			OF Was seen released to modical								2 (3kNo	1 [	Yes	2 No	
of Vital		Be	25. Was case relerred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	- 2 DO	Othe			(Check only o			/0		
of	Phys r this ral di	To	27. Manner of Death	28a. Date of Injury	28b. Time o		c. Injury Work	4 🗆 140		me 5 X Resid 28d. Describe h				iry)	
Division	Attending I r death. octor: After by the funer	Certification:	1 StNatural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	М		:? /es 2 □	No						
/isi	Attendi	flca	3 ☐ Suicide 6 ☐ Could not b	286. Place of injury -		reet, lactory,	office			281. Location (S		Number	r or Rui	ral Route Nurt	ıber,
Dİ	afte Dire	ert	4 Homicide	building, etc. (S	ipecity)					City or Tow	vn, State)				
	spits tours neral		29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, deal	th occurred a	t the tim	e, date an	d place,	and due to the	cause(s) a	and man	ner as	stated.	
	• Ho • Fu • Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated.	amination and/or in	vestigation,	n my op	sinion, dea	th occur	ed at the time, o	date and p	place, an	nd due	to the cause (s	;)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and the ol certifier	2//		29c.		number				_		Day, Year)	
	-		1/610	PX1 61-	1	ļ	D4	1828			Dece	mber	5,	2005	
	5		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)					-				
			Clara Chan, M.D.	9801 Georg	ia Avenu	e, #33	7,	Silve	r Sp	ring, MC	209	02			
1. A. A.	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	whi									

I THE THE		1. Decedent's Name (First, Middle, L	.ast)		-		2. Date of Death	Day	3. Time of Death
hysicia /Medica		SOLOMON	F	KOKER			Month DECEMBER	2 2005	4:52A M
amine		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Death		4c. County of Dea	
		SUBURBAN HOSPIT			ROCKV			MONTGO	
ral tor		5. Social Security Number  245-25-9783  Usual Residence of Decedent	Sex 7. Age (In ) 1 ★ 2 F 56	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y MAY 13 19	9. Bir 949 SIE	thplace (State or Foreign ountry) RRA-LEONE
=		10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
Circl (racinatic event, interpretable fracting) - that be nathridged	cto	MD MONTGOM	IERY S	SILVER S	PRING				1 No 2 No
	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	ra	9203 NEW HAMPSH			20903			J.S.A.	
	by Funeral Director	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 ☒ Married</li> <li>3 ☐ Widowed 4 ☐ Divorced</li> </ul>	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spe lan, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of workind)	ng 16	b. Kind of Business	/Industry
	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4+		GEMENT	/		PRIVATE	
	To Be C	17. Father's Name (First, Middle, Las MUSTAPHA KOKER	st)			18. Mother's Name HAWA MOO	(First, Middle, Ma.	iden Sumame)	
		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	Route Number, C	ity or Town, State, a	Zip Code) 20903
		FATMATA KOKER/W							NG, MARYLAND
1		20a. Method of Disposition 1   Burial 2 □ Cremation 3			sition (Name of matory or other pla	ce) Jan. I	, 2006	c. Location - City or	
1	F	`4 □Donation 5 □ Other (Spec		FAMILY P					SIERRA LEON
once.		21. Signature of Funeral Service Lice	ensee ()			OVER ROAD			
	-	23a. Part1. Enter the disease, or co	molications that caused the d						
n		Immediate Cause (Final	y one cause on each line.			9,	Troophatory arross		Approximate Interval Between Onset and Death
i	1	disease or condition resulting in death)	a. BRAIN HER	RNIATION					
r			STROKE	304401100 01).					
4	Jer	Sequentially list conditions, if any, leading to immediate cause Exter or certains Cause (Disease or injury	Due to (or as a con-	sequence of):					41.040.00
	EXa	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con.	sequence of):					
	VMedi	IF FEMALE:	23c. If yes, outcome of pre	gnancy				22d Date of del	
- 13	S S	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of del Month	Day Year
	nysi	9 Unknown							
		9 Unknown Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	2 ,		contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	1		the cause of death?
	2 ,		contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	1	2 No 3 Production Production 24b. Were au prior to death?	obably 4 Unknown topsy findings available completion of cause of
	Completed by			resulting in the u		26. Place of Death	1 Yes  24a. Was an autopsy performed 1 Yes 20 (Check only one)	2 No 3 Production of the prior to death?	topsy findings available completion of cause of 212 No
	to be completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1 \( \triangle \text{Yes} \) 2 \( \triangle \text{No} \)	Hospital: 1 K Inpatient 2	2 □ ER/Outpatien	t 3□ DOA <sup>Oth</sup>	26. Place of Death er: 4 □ Nursing Hom	1 Yes  24a. Was an autopsy performed 1 Yes 20 (Check only one)	2 No 3 Production of the state	topsy findings available completion of cause of 212 No
	to be completed by	25. Was case referred to medical examiner?  1 Yes 2 No  2 Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 🖾 Inpatient 2 28a. Date of Injury (Month, Day Year	2 □ ER/Outpatien	t 3 DOA Oth	26. Place of Death er: 4 □ Nursing Hom y at 2 k? Yes 2 □ No	1   Yes  24a. Was an autopsy performed   Yes 2\( \) (Check only one)  10   S   Residence   S	2 No 3 Production of the second of the secon	topsy findings available completion of cause of 250 No
	to be completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 X Inpatient 2 28a. Date of Injury (Month, Day Year	2 ☐ ER/Outpatien  28b. Time of Injury	t 3 DOA Oth	26. Place of Death er: 4 □ Nursing Hom y at 2 k? Yes 2 □ No	1   Yes  24a. Was an autopsy performed   Yes 2\( \) (Check only one)  10   S   Residence   S	2 No 3 Production of Production of State of Production of State of Production of Produ	topsy findings available completion of cause of 250 No
	Ceruication: 10 Be Completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending investigating investigating the state of the period of the state of the st	Hospital: 1 X Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien  28b. Time of Injury  at home, farm, streecity)  knowledge, death	t 3 DOA Oth  28c. Injur  Wor  M 1 DOA	26. Place of Death er: 4 \sum Nursing Hom y at 2: k? Yes 2 \sum No	24a. Was an autopsy performed 1 Yes 20 (Check only one) is 5 Residence 8d. Describe how is 6f. Location (Stree City or Town, S	2 No 3 Production of Production of Production of Seath?  24b. Were authorized to death?	topsy findings available completion of cause of 21 No cify)
	ledical Certification: 10 be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine.  29a. Certifier (Check only 2 Medical Exe	Hospital: 1 1 Inpatient 2 28a. Date of Injury (Month, Day Year  28e. Place of Injury - A building, etc. (Spe  hysician: To the best of my miner: On the basis of exam	2 ER/Outpatien  28b. Time of Injury  at home, farm, streecity)  knowledge, death	t 3 DOA  28c. Injur Wor 1 = set, factory, office	26. Place of Death er: 4 Nursing Hom y at k? Yes 2 No  2 me, date and place, at pinion, death occurre e number	24a. Was an autopsy performed 1 Yes 2 (Check only one)  16 5 Residence 8d. Describe how in the City or Town, Sound due to the caused at the time, date	2 No 3 Production of Production of Production of Seath?  24b. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death?  24c. Were authorized to death.	topsy findings available completion of cause of 250 No cify)  ral Route Number, stated. to the cause(s)
	ledical Certification: 10 be Completed by	25. Was case referred to medical examiner?  1	Hospital: 1 1 Inpatient 2 28a. Date of Injury (Month, Day Year  28e. Place of Injury - A building, etc. (Spe  hysician: To the best of my miner: On the basis of exam	2 ER/Outpatien  28b. Time of Injury  at home, farm, streecity)  knowledge, death	t 3 DOA  28c. Injur Wor 1 = set, factory, office	26. Place of Death er: 4 \( \to \) Nursing Hom y at k? Yes 2 \( \to \) No	24a. Was an autopsy performed 1 Yes 20 (Check only one) lie 5 Residence 8d. Describe how in the City or Town, S and due to the caused at the time, date 29d.	2 No 3 Production of the state	topsy findings available completion of cause of 21 No cify)  ral Route Number,  stated. to the cause(s)

			For State Registrar	State	of Marylar		irtment of tificate of		Mental Hyg	jie∱e∏ leg. No.	5 4	
	Physici /Medic	900	Decedent's Name (First, Middle     Ben jan	<sub>e, Last)</sub> nin J. Kelly	y Sr.				2. Date of Dea Month	r 27 2	Year	3. Time of Death
	Examir	An .	4a. Facility Name (If not institution  Doctor's Comunity	-	umber)			or Location of Dea	ath	4c. County Prince	of Death George	S
74	Funeral Director		5. Social Security Number 578-44-3938	6. Sex 1∕3 M 2 ☐ F	7. Age (In yrs.	/ast birthday) 71 Yrs.	If Under 1 Year Months Days			1934	9. Birthplac Washii	gton, D.C.
	ehow	ž	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo		ashington			10d	. Inside City Limits
	with the M 3a or 28a-f 1 be notifie	Funeral Director	D.C.  10e. Street and Number  731 Shepherd Sta	æt. N.W.			10f. Zip Code	20011	1	10g. Citizen of V		
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or iteme 23e or 28e-f ehow event, I're Medical Eraminal maint be notified at	by	11. Marital Status  1 Never Married 2 Marr  Widowed 4 Divorced	12. Was De Armed F ned 1 Tyes	2 📉 No live		Vas Decedent of Yes, specify Cu		Specify Yes or No- erto Rican, etc.)		ce - American ck, White, etc	
0-6121	filed within 72 ho Hygiene. other than "natur ent, Ina Medical	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12th grade		() (1-4or 5+)	(Give	ent's Usual Occu kind of work done OO NOT use retire	during most of ward)	orking	16b. Kind of B		stem (Retired
Maryland 2	should be filed wit nd Mental Hygien marked other th imatic event, Ire	To Be Co	17. Father's Name (First, Middle,	h Kelly				18. Mother's Na	ame (First, Middle, I		ne)	
	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 le marke eny injury or other traumatic 0000.		Sherita Muzan (I		200	5117 C	buntry La	ne Seat Ple	Rural Route Number Pasant, Mary Date	yland 20	743	
Baltimore,	it. Pages I intment of H intent: If Ite njury or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	pecify)	n State	esapeake	sition (Name of natory or other pl Crematory . Name and Addi	, Inc. Dec	ember 5, 20		sville,	Maryland
Ba	permit. Departi Importi eny inj		I fruit C	· hide	con	43:	39 Hunt Pl	ace, N.E.	Rollins Fu Washington,	D.C. 20	0019	
	Physician /Medical		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	each line. Arrythmia		er the mode of dy	ing, such as cardi	ac or respiratory arr	est,	In	pproximate terval Between nset and Death
ı	Examiner		Sequentially list conditions.	ь	o (or as a consec Hypóxia							
68760,	ficate be executed physicien and is the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>S</b>	o (or as a consec							
O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregn birth 2 Feta gnant at time of c nown	aldeath 3 🗆	Ectopic pregnani Other (specify)	ey .		1	te of delivery onth Da	ay Year
rds, P.	The law requires that the de tte has been signed by the s bage 2 should be detached t	by	Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cause g	ven in Part I.				cause of death?
Vital Records,		Completed							24a. Was a autops perform	n 24b. y y med? 2 X No	Were autopsy prior to comp death? 1 ☐ Yes 2	y findings available letion of cause of
	ysicien is certif director	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2X	ER/Outpatien	t 3□ DOA O	har	eath (Check only on Home 5 Reside		er (Specify)	
Division of	Attending Ph death. ctor: After thi y the funeral		27. Manner of Death  1 XNatural 5 Pendir 2 Accident investi	ng (Mo gation	e of Injury nth, Day Year)	28b. Time of Injury	28c. Inju We M 1		28d. Describe ho	T		
Š	Oire In b	Certification:	3 Suicide 6 Could determ	nined 288. Plac buil	se of Injury - At h ding, etc. (Speci	ify)			28f. Location (Si City or Town	n, State)		
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifyir (Check only one)	Examiner: On the	ne best of my kno basis of examina nner stated.	ation and/or inv	estigation, in my	ime, date and place opinion, death occ	ce, and due to the co curred at the time, d	ause(s) and ma ate and place,	anner as state and due to th	ed. e cause(s)
	To the within To the comple	M	29b. Signature and title of certifie	XXH	Jur	CV	29c. Licer	se number	<b>\</b>	9d. Date signer	d (Month, Da	y, Year)
)			30. Name and address of person  VR Teffrey	who completed car	use of death (Ite	m 23a) (Туре,	Street	Lou	rel md	2070	07	
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Sign	ature do	(E)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 24a per mr 9850 12-22-05 vt
State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) ANN S • KELLY 2. Date of Death 3. Time of Death **Physician** 2005 13, Dec. q00:8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3302 Jourdan Avenue Darlington
If Under 1 Year | If Under 24 Hrs. Harford 8. Date of Birth

/Month Day, Year)
7/20/1922 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖺 F 83 Yrs. Director 215-14-0558 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show in than "natural", or Items 23a or 28a-f show the Mcdical Examiner in ust be notified at 1 TYes 2 □ No MD Harford Darlington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3302 Jourdan Avenue 21034 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Much. 900.9. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Hopkins Scott Martha Bissell Spalding ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan K. Burchett/Daughter 709 Priestford Road, Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Darlington Cemetery 12/17/05 ^ 4 □ Donation 5 □ Other (Specify) Darlington, MD 21. Signator of Funeral Service Ligensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA
enter the mode of ring, such as cardiac or respiratory arrest,
interval Between
Onset and Death Part 1 Enfort the disease, or complications that caused the obath. Do not enter the mode of wing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Wasian Pnysician entine 2.5 Lance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine as the burial-transit The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 2 100 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 🗆 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 2 XN0 1 🗌 Yes To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

6694

William Water vield,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9103 Franklin Square Drive, Baltimore, M.D.,

12/14/2005

12137

			1 - For State of Maryland / Dep	partment of Health and ertificate of Death	d Mental Hygie	C 0 0 0	41416
	Physici	an	1. Decedent's Name (First, Middle, Last) William Leslie Kemp		2. Date of Death Month December	Day 9, 2005	3. Time of Death 2:00 A <sup>M</sup>
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Deat	
2			37605 Louis Bailey Road	Avenue		Saint Man	-
4	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 XM 2 F 74 Yrs.	y) If Under 1 Year If Under 24 H Months Days Hours N	Min. 8. Date of Birth (Month, Day, Y) Dec. 19, 1	ear) Co	hptace (State or Foreign ountry) cyland
	and ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			10d. Inside City Limits
	e Man	ctor	Maryland Saint Mary's	Avenue			1 ☐ Yes 2 No
	with the	Director	10e. Street and Number	10f. Zip Code 20609	10g	. Citizen of What Co	ountry?
	ms 23	Funerai	37605 Louis Bailey Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	USA 14. Race - Ame	
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Fur	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No  1 ☐ Yes 2 ☐ No  1 ☐ Yes Give  Year or Dates:	If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes X No Specify:	uerto Rican, etc.)	Black, White Specify: Who	
2-0	72 hou natura	eted		edent's Usual Occupation re kind of work done during most of	working 16	b. Kind of Business/	Industry
121	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ob Foreman		own on twi	
1 2	other ent,	Be Co	17. Father's Name (First, Middle, Last)		Name (First, Middle, Ma.	Carpentry Iden Sumame)	
ylar	Duid be Menta arked atic ev	ToB	George William Kemp	Leon A	Adelaide Fav	vcett	
Mar Mar	d 2 sho th and 7 is m traum			iling Address (Street and Number or			Zip Code)
ē,	s 1 en f Heel item 2 other	1	20a. Method of Disposition 20b. Place of Dis	05 Louis Bailey F position (Name of ematory or other place)		c. Location - City or	Town, Slate
<u>E</u>	Page ment c ant: if ury or	١,	I X Buriai 2 Cremation 3 Cremoval from State	Peace Cemetery Dec	. 13, 2005 H	Helen, Mar	ryland
Baltimore, Maryland 21215-0036	permit. Departimporti importi eny inj		21. Signature of Funeral Service Licensee  Much red Yourn Handom	22. Name and Address of Facility Mattingley-Gardine P.O. Box 270, Leon.	r Funeral Home	P.A.	
	×		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as care	diac or respiratory arrest	,	Approximate Intervat Between
100	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	IETIVE PULMON	MY Maria		Onset and Death
	Examiner		Due to (or as a consequence of):			7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
,*	pei lisit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
o,	cate be executed physician and the burial-transit	Examine	that initiated events c				
	cate by physic the bu	dicai	d				
Box 6	leath certific: attending pt for use as t	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	ivery
Ö.	The law requires that the death certific ste has been signed by the attending p bage 2 should be detached for use as	Physician/Me		☐ Cther (specify)		Month	Day Year
o. O.	es that I igned by be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	ted	CONONARY ARTERY DIFFAR HYPERTENSION	~	1 ☐ Yes	2 No 3 Pro	obably 4 □Unknown
Rec	The law cate has b page 2 sh	Completed by	HYDRIENSIC I		24a. Was an autopsy performer	d? death?	topsy findings available completion of cause of
ita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical	26. Ptace of	1 □ Yes 2 Death Check only one	No 1∐Yes	2□ No
<u>&gt;</u>	Physician: this certificantal director, it	ို	examiner?    Hospital: 1   Inpatient 2   ER/Outpati		g Home 5 Aesidenc		city)
o O	ding h. After fune	tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)  Injury		28d. Describe how	injury occurred	
Division of Vital Records,	i or Attenater deatl	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru state)	Iral Route Number,
	pital curs erai filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de-	ath occurred at the time, date and pl	ace, and due to the caus	e(s) and manner as	stated.
	To the Hos within 24 h To the Fun completely	<b>ledica</b> i	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.				
)	7 wit	Σ	29b. Signature and title of certifier  MD	29c. License number		Date signed (Monti	n, Day, Year)
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	Sta	te		,	, on I was	, , , , ,	56
	Registr	4	DEC 1 2 2005	K			

			1 - For State Ragistrar	State of N	/larylar	-		nt of H te of L		ind M		gierrie leg. No.	005	4 14	17
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ith Day	Year	3. Time o	of Death
	Physici /Medio		Maude Elizabeth	n Knott							Decembe			2:03	P M
	Examin		4a. Facility Name (If not institution, giv				4b. Cit	, Town, or	Location o	f Death			ounty of Death		
			Southern Maryland				17.10- 4		inton	2411			nce Ge		
	Funeral		5. Social Security Number 6. S	Sex 1□M 2XIF		last birthday) Yrs.	Month	or 1 Year Days	If Under 2 Hours	Min,	8. Date of Birtl (Month, Da)	r, Year)	9. Birth	place (State intry)	or Foreign
	Director		220-32-5339 Usuel Residence of Decedent		69		1				August 1	+, 193	o mary	land	
yland	Mo T		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside C	
Mag	- 1	ctor	Maryland Saint M	lary's		Leo	nard	town						1 🗆 Yes	s 2X No
E E	or 28	Director	10e. Street and Number				10f. Z	ip Code				10g. Citize	n of What Cou	intry?	
ath w	238	ra	21864 Joe Hazel						650				USA		
rs after de	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f ehow any injury or other traumatic event, the Mudical Exeminer must be notified at ODGE.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1  Yes 2X If Yes, Give Year or Dates	ș? ]No	-		edent of Hi ecify Cuba 2 No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	1	Bace - Amer Black, White Pecify: Whi	, etc.	
2 Por	atura		15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occupa	ition	a f wade	ina	16b. Kind	of Business/l	ndustry	
7 oid	F 1	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT	use retired	luring most )	OF WORK	nking				
<b>7</b> M	gien er th	Son	12			Human	Ser	vice		-			ernment		
3 8	d oth	Be	17. Father's Name (First, Middle, Last								First, Middle,		umame)		
	I Men narke natic	မ	Joseph Raymond T			105 14-15	8-1-1				Morgar		Faum Ctata 7	o Codel	
42 st	h and 7 la n traun	r i	19a. Informant's Name/Relationship ( Janet Williams /		•		_				exingto:				
בּ בַ	Heall tem 2 other	1 8	20a. Method of Disposition		20b. l	Place of Dispo	sition (N	ame of			Date		ition - City or 1		
3008	t: ff lt y or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		(8)	cemetery, cre arles Me	-		.	Dec :	19, 2005	Laona	rdtown	MD	
mif. Pages	artme ortan injur	1	21. Signatur of Funerary Service Lice				2. Name	and Addres	s of Facility	у				, FIL	
0 8	Depa Impo any is		Muchael	Jaro	lin	er	Mat P.O	tingley Box 2	y-Gardi 270, Le	iner i eonar	Funeral H dtown, MD	ome, P 20650	.A.		
- 1	nysician Medical xaminer		23a. Part I. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Athenoxle notice (and various)  Due to (or as a consequence of):												neewte
certificate be executed		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Due to (or a d.											
the death certifi	y fhe attending iched for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)				23	d. Date of delin		Year
wrequires the	n signed b	۵	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	ınderlying	cause give	en in Part I.			bacco use es 2 🗆	ocontribute to		death? Unknown
The Late	ete has	Completed									24a. Was autop	an sy med? 2. No	24b. Were aut prior to c death? 1 \( \text{Yes}	opsy findings ompletion of 22 No	available cause of
	is certific director,	Be (	25. Was case referred to medical examiner?	11						of Deatl	h (Check only o	ne)			
Off Of VICE	n. After this funeral di	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpa 28a. Date of li (Month, li		ER/Outpatie 28b. Time o Injury		28c. Injury Work	4 🗆 140		me 5 ☐ Resid 28d. Describe h			ify)	
DIVISION tal or Attending	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not to determined	289. Place of	Injury - At h etc. (Speci	ome, farm, st	reet, fact	ory, office			28f. Location (S City or Tow		Number or Ru	al Route Nur	nber,
ine Hospi	within 24 hours af To the Funeral D completely filled in	edical		hysician: To the be minar: On the basis and manner	of examin										(s)
T of	Vith Com	Σ	29b. Signature and title of certifier				2	9c. License			-		signed (Month		
			modar	~					536-				15-20		
			30. Name and address of person who	completed cause of 4. Rou 5.	of death (Ite	m 23a) (Type (フ▽/	Print)	rgsto	n ad	#10	I, Fiw.	Ashi-	often 1	4620	74
of .	Sta Regist	ate trar	31. Date filed (Month, Day, Year) 6	2005 32. 8	strar's Sign	ature	Spen						-		

Director    Straight	Birth Day, Year) 14, 1924  10d. Inside City Limits 10g. Citizen of What Country?  United States									
Theodore Cresswell Lewis  Theodore Cresswell Lewis  4a. Facility Name (If not institution, give street and number)  Joseph Richey Hospice  Funeral Director  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1 Medical  10a. State If Under 1 Year If Under 24 Hrs. Nim. July  10b. County  10c. City, Town or Location  Washington  10f. Zip Code  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Named Forces?  11d. Marital Status  11d. Named Forces?  11d. Named Forces?  11d. Named Forces?  11d. Named Forces?  11d. Marital Status  11d. Named Forces?  11d. Named Forces?	Birth Jay, Year) 14, 1924  9. Birthplace (State or Foreign Country) 14, 1924  10d. Inside City Limits 1 Wes 2 No  10g. Citizen of What Country?  United States  No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
4a. Facility Name (If not institution, give street and number)  Joseph Richey Hospice  Funeral Director  5. Social Security Number 5. Sex 1 Months Days Hours Min. July  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  DC Washington  10d. Zip Code  3321 Alden Place, N.E. 20019–1314  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)	Birth Day, Year) 14, 1924  9. Birthplace (State or Foreign Country) Virginia  10d. Inside City Limits 1 Wes 2 No  10g. Citizen of What Country? United States  No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
Joseph Richey Hospice  Funeral Director  S. Social Security Number  5. Social Security Number  6. Sex  18	Day, Year) 14, 1924 Virginia  10d. Inside City Limits 1 Wes 2 No  10g. Citizen of What Country?  United States  No-  14 Race - American Indian, Black, White, etc.  Specify: Black									
Director    State   10b. County   10c. City, Town or Location   10f. Zip Code	Day, Year) 14, 1924 Virginia  10d. Inside City Limits 1 Wes 2 No  10g. Citizen of What Country?  United States  No-  14 Race - American Indian, Black, White, etc.  Specify: Black									
Director    State	14, 1924 Virginia  10d. Inside City Limits  1 □ Wes 2 □ No  10g. Citizen of What Country?  United States  No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
To a State 10b. County 10c. City, Town or Location  Washington  10a. State 10b. County 10c. City, Town or Location  Washington  10f. Zip Code  3321 Alden Place, N.E. 20019–1314  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerlo Rican, etc.	10d. Inside City Limits  1 □ Wes 2 □ No  10g. Citizen of What Country?  United States  No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
DC    10a. State   10b. County   10c. City, Town or Location   10c. City Town or Location   10c. City Town or Locat	1 ☐ Yes 2 ☐ No  10g. Citizen of What Country?  United States  No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
DC  10e. Street and Number  10f. Zip Code  10e. Street and Number  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  11f. Marital Status  11 Marital Status  12 Was Decedent Ever in U.S. Armed Forces? 11 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 11 Never Married 2 Married 3 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Give kind of work done during most of working life. Do NoT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	10g. Citizen of What Country?  United States  No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
10e. Street and Number  3321 Alden Place, N.E.  20019–1314  11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19. James G. Lewis	No-  14. Race - American Indian, Black, White, etc.  Specify: Black									
3321 Alden Place, N.E.  20019-1314  11. Marital Status  1 Never Married 2 Married  1 Never Married 2 M	No- 14 Race - American Indian, Black, White, etc. Specify: Black									
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. Never Married 2. Married 1. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerlo Rican, etc If Yes, specify Cuban, Mexican, Puerlo Rican, etc If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerlo Rican, etc If Yes, Specify Cuban, Mex	Specify: Black									
1   Never Married   2X Marned   1   Yes   2X No   Specify:   1   Yes   X										
The state of the s										
Specify only highest grade completed)  [Specify only highest grade completed]  [Specif	16b. Kind of Business/Industry									
College (1-4or 5+)  Elementary/Secondary (0-12)  12th  To Father's Name (First, Middle, Last)  Lames G. Lewis  College (1-4or 5+)  Nursing Assistant  18. Mother's Name (First, Middle, Last)										
Nursing Assistant  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  James G. Lewis	0									
U PES O James G. Lewis	Government									
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James G. Lewis  George De De De De De De De De De De De De De										
James G. Lewis  James G. Lewis  19a. Informant's Name/Relationship (Type, Print)  Page 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19										
Cora L. Blair/Friend  3321 Alden Place, N.E. W.  20a. Method of Disposition  20b. Place of Disposition (Name of Competent Comp	20c. Location - City or Town, State									
To solve the state of the solve that the solve tha										
4 Donation 5 Dother (Specify) Lincoln Memorial Cem. 12/10/200.										
1 Carrial 2 Cemation 3 Removal from State 4 Conation 5 Other (Specify) 21. Signature of Fineral Service Licensee 4 001 Benning Rd., N.E	Funeral Home Wash., DC 20019									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato	y arrest, Approximate									
Immediate Gause (Final	snock, or near failure. List only one cause on each line.									
/Medical resulting in death)  Due to (or as a consequence of):	I JIIA LIPS									
Examiner :										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
3 2										
o विस्ति प्राप्त resulting in death) Last Due to (or as a consequence of):										
Due to (or as a consequence of):										
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   2   Unknown   2   Other (specify)   9   Unknown   9   Unknow	23d. Date of delivery									
in the past 12 months?    The past 12 months   The past 12 months	Month Day Year									
	d tobacco use contribute to the cause of death?									
24a. Van Description of the second of the se	☐ Yes 2☐ No 3☐ Probably 4 ☐ Minown									
Say of the last peans and the la										
The Recognition of the Page 2 and Page 2 and Page 2 and Page 3 and	prior to completion of cause of death?									
To be a considered to predict the constant of										
25. Was case referred to redical examiner?  1 Yes 2 1 16 Hospital:  1 Inpatient 2 ER/Outpatient 3 DOA Cher. 4 Nursing Home 5 F	esidence 6 Dother (Specify)									
27. Manne of Death 28a. Date of Injury 28b. Time of Injury at Work?	be how injury occurred									
O D D D D D D D D D D D D D D D D D D D										
To state the control of the control	(Street and Number or Rural Route Number,									
27. Manne of Death  1	Town, State)									
	ne cause(s) and manner as stated.									
29a. Certifier  Check only one)  29a. Certifier  (Check only one)  29b. Certifier  (Check only one)  20c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	e, date and place, and due to the cause(s)									
and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)									
1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	1211185									
30. Name and address of person who combined catise of death (Item 23a) (Type, Print)	111/00/-									
FU John by Parner MD 4811 UNNOXUIDINIKA	DUND MIZIZIP									
	11/1/1									
State 31. Date filed (Month, Day, Year)  Registrar  DEC 0 7 2005										

			State of I	Maryland / Depa		lealth and Mo	ental Hygie	<b>ne</b> 0 0 5	41419
			- State Registrar	Ce	Tuncate or		Reg. 2. Date of Death	No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)			-	Month	Day Year	
	/Medic	al	Dorothy Elaine LaBount		Ab City Town o	r Location of Death	December	1, 2005 4c. County of Death	12:05 a.™
	Examin	er	4a. Facility Name (If not institution, give street and numb	91)				,	_
			3218 Tucker Road  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Fort Was		8. Date of Birth (Month, Day, Ye	Prince Ge	place (State or Foreign untry)
	Funeral Director		577-40-7464 1□M 2XPF	76 Yrs.	Months Days	Hours Min.	Month, Day, Yo.	29 Virs	intry) Zinia
			Usual Residence of Decedent						
	ylan		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma	cto	Maryland Prince George's	Fort Wa	shington				1 ☐ Yes 21X No
	or 28	Director	10e. Street and Number		10f. Zip Code		- 68	Citizen of What Co	untry?
	23e		3218 Tucker Road		20774			1.S.A.	fana la dia a
	er de	nne	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9	or I	by Funeral	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	E No	1 ☐ Yes 2 ☐XNo	Specify:		Specify: Wi	nite
Ş	filed within 72 hours after death with the Maryland Hygiene. Hygiene, the Wither than 'natural', or items 23a or 28e-f ahow ent, the Medical Examiner must be reutified at ent.	ed t	15. Decedent's Education	16a Dece	edent's Usual Occup	ation	16	b. Kind of Business/l	ndustry
5	in 72	olet	(Specify only highest grade completed)	(Give	e kind of work done DO NOT use retired	during most of working)	ng		
7	thar thar	Completed	Elementary/Secondary (0-12) College (1-4	Boo	kkeeper		Ţ	J.S. Gove	rnment
0	Hyg othe ent.	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name			
a	should be f and Mental I s marked of umatic eve	To B	Walter Raymond Shipe, S			Ruth Bal	dwin Kerı	ns	
Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be realified at once.	5	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura			ip Code)
Ž	and 2 saith n 27 I		Doris Elaine Miller (Da		W-100	lvert St.			46613
ore.	of He of He fiten		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Removal from St.		osition (Name of ematory or other plac	ce)		c. Location - City or	
Ĕ	Page		`4 □Donation 5 □ Other (Specify)	Remingt	on Cemete	ery Dec.4	,2005 Re	emington,	/irginia
Baltimore,	ormit. opart oport ny inj		21. Signature of Funeral Service Licensee		22. Name and Addre	ье	e Funeral		00100
<u> </u>	20523		front for done	1	8521 Sud			, Virginia	
			23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do not en h line.	nter the mode of dyir	ng, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ulvar Ca	now				
	/Medical Examiner		resulting in death)  Due to (or	as a consequence of):					
	LAAIIIIIEI	_	Sequentially list conditions, b.	as a consequence of:					
	ed isit	Examiner	Sequentially list conditions, if a.y., Jacob to Inmediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a no sequerac or,					
	and and II-trar	xan	that initiated events c. Due to (or	as a consequence of):					
90	ate be executed nysician and he burial-transit	calE						Ĭ	
68760,	tificate ng phys as the		0.	7 - 7.10 N					
×	certit nding use a	Z/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the property of th		<b>-</b>			23d. Date of deli	very
Вох	death a atter	ciai	in the past 12 months? 4 Pregnar	nt at time of death 5	□Ectopic pregnanc □ Other (specify) _	<i>y</i>		Month	Day Year
P.O.	The law requires that the death certifical sie has been signed by the attending phy agge 2 should be detached for use as the	by Physician/Med	9 Unknown 9 Unknow	'n					
	res tha signed I be det	y P	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Ĕ	v require been sig should b						1 🗆 Yes	2 <b>74</b> No 3 ☐ Pr	obably 4 Unknown
ပ္တ	aw requas been 2 shoult	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
æ	The lav cete has page 2	Eo					performe 1 ☐ Yes 2 ☐	d?   death?	
<u>ta</u>		Bec	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
<b>}</b>	ys di	10		patient 2 ER/Outpatie	all SULDON		ne 5 Residenc	e 6 Other (Spec	cify)
0 _	ng Pt fter tt nera		27. Manner of Death 1 Saatural 5 Pending 28a. Date of (Month,	Injury 28b. Time Injury	Wo		28d. Describe how	injury occurred	
Sio	Attending r death. sctor: After by the fune	catio	2 Accident investigation			Yes 2 □ No	20(		
Division of Vital Records,	or Att	Certification;	determined 288. Place C	f Injury - At home, farm, s j, etc. <i>(Specify)</i>	treet, factory, office	2	City or Town, S	et and Number or Ru State)	rai Houte Number,
Ω	urs at oral D			and the second of the second	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	and data and along	and due to the cour		atatod
	To the Hospital or Attending Phythin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the base one) 2 Medical Examiner: On the base and manner	is of examination and/or i	investigation, in my	me, date and place, a opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the	Mec	29b. Signature and title of certifier	states.	29c. Licen	se number	29d	. Date signed (Monti	h, Day, Year)
	F 5 5		111/1/6/0		D3	SZela	7	) oco alba	2 2NY
-	10/		30. Name and address of person who completed cause	of death (Item 23a) (Type	a. Print)			CEW W	- 200
1	all		W. Kim T. TANNER W	11701 Lus	ing son R	152ch	MASHITG	m mn 20	ny
	St	ate	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	•				-
	Regist		DEC 0 8 2005	feel !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Tice Lee Sue December 7. 2005 8:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Genesis Healthcare of LaPlata LaPlata Charles 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 27 XF 577-42-4754 Director BALT.MD May 18, 1923 Usual Residence of Decedent filed within 72 hours after death with tha Maryland 10a. State 10c. City, Town or Location orent: If item 27 is marked other than "natural, or items 23e or 28a-f show injury or other treumatic event. It is Medical Exercities and 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo LaPlata Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 USA 103 Thrush Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor - Accounts Rec. Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Tice Julia Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Thrush Court LaPlata, Maryland Pamela A. Lee / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Washington Nat. Cemetery 12/10/2005 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one says on each line.

Immediate Cause (Final disease or condition) 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death neumoni **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exacuted attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 🕇o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 3x√x No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🛣 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No neret Diractor: A investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a MX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29b. Signature and title of certifier Mahin Mathu 29c. License number 29d. Date signed (Month, Day, Year) D52289 12/8/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nalin Mathur MD 10 St. Patricks Drive #404 Waldorf, Maryland Date filed (Month, Day, Year) 32. Registrar's Signature State ULU 0 8 2805 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State of M	Maryland	-	artment of rtificate of			_	iene	15	41421
			1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		ROBERTA	PEARL			LEE		D	ECEMBER	2 06, 2	2005	3:30P M
	Examin		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town, or Location of Death			4c. County of Death			
		ш	LARKIN CHASE N					VIE .			PRINC		
	Funeral		,	6. Sex   7. / 1 □ M <b>X</b> (X) F	Age (In yrs. I	ast birthday) Yrs.	Months Days		Min.	<ol> <li>Date of Birth (Month, Day,</li> </ol>	Year)	9. Birthr	place (State or Foreign ntry)
	Director		225 20 4037 Usual Residence of Decedent		92	115.				SEP. 22	,1913_	VIRG	INIA
	land ow		10a. State 10b. County	<u>.</u>	10c. City	, Town or Lo	ocation		.,				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	02011025			10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show		624 DRUM AVENUE				2	0743			UNITE	STA'	TES
	deat	Funeral	11. Marital Status	12. Was Deceder Armed Force		S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Or	rigin? (Spec	cify Yes or No-		ce - Americ	
٥	after or Ite		1 Never Married 2 Marrie				1 □ Yes XX No			10011, 010.7	l l	by: BLA	
3	be filed within 72 hours after death with the Marylar ital Hygiene. Id othar than "natural", or Items 23a or 28a-1 show avant, the Medical Exert increment by rediffical at	d by	XX Widowed 4 □ Divorced	Year or Dates	s:								
7	"nat	Completed	15. Decedent' (Specify only highes			(Give	dent's Usual Occu kind of work done DO NOT use retin	during mos	st of workin	g	16b. Kind of E	Business/In	dustry
Z	filed within 72 Hygiene. other then "net ant, the Medici	ш	Elementary/Secondary (0-12) 12TH	College (1-4d	or 5+)		USEWIFE	50)			OWN HO	ME	
ק ס	filed Hygi thar		17. Father's Name (First, Middle, L	ast)			DOEMTLE.	18. <b>M</b> oth	er's Name	(First, Middle, M			
Maryland 21215-0036	should be ind Mental Indexed o	To Be	JOHN WAVERLY PL	FASANTS				MAT	TTTE V	VINGFIEI	D ROBI	NSON	
2		-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Stree	-					Code)
	and 2 ealth a n 27 ls		CLAUDETTE CHAME	ERS / DAUG	HTER	624 1	DRUM AVE	NUE (	CAPITO	OL HEIGH	HTS, MI	207	43
e G			20a. Method of Disposition	- TP - 14 - 24		ace of Dispo	sition (Name of matory or other pla				20c. Location		
Ĕ	Pages nent of I int: If its iry or o		XX Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp	3 ⊟Hemovai from Sta ecify)	10		T. OLIV	1	4 DEC	2005	RICHM	IOND.	VA
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icensee		the same of the same of the same of	MARSHAL!			CONTRACTOR OF THE PARTY OF THE			
<b>n</b>	80 5 5 8		7. 11 a	rishle			4308 SU						
			23a. Part Enter the disease, or shoot or heart failure. List of	complications that caus only one cause on each	sed the death I line.	. Do not ent	er the mode of dy	ring, such as	s cardiac or	respiratory arre	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ience of):							
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	al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	ience of):							
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2	g physias the	ledle							-				
ROX	eath certifii attending p for use as	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1□Live birth			JEctopic pregnan	CV				ate of delive	
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	res that igned be be det	by	Part II. Other significant condition	ns contributing to death	n but not resu	ilting in the u	nderlying cause g	iven in Part	t.				he cause of death?
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<b>Records</b> ,	a law	Completed								24a. Was ai	v	prior to co	psy findings available mpletion of cause of
		Co								perform 1 □ Yes 2	(X) No	death?	2 🗆 No
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:						(Check only on		-	
	Phys this ral dir	7	1 ☐ Yes 🏋 ☒ No 27. Manner of Death	1 ☐ Inpa	atient 2 🗆 E	ER/Outpatier 28b. Time o				ie 5 ☐ Reside 8d. Describe ho			(y)
o	ding F h. After funer	tlon	XXNatural 5 Pending 2 Accident investig	(Month, l	Day Year)	Injury	W	ork? ⊡Yes 2.⊟			,,		
Division of	I or Attandi after death. Diractor: A I in by the fu	fica	3 Suicide 6 Could n	ot be 28e. Place of	Injury - At ho	me, farm, str	eet, factory, office	)	28			ber or Rura	al Route Number,
É	spital or A ours after laral Diral filled in by	Certification:	4 Homicide	building,	etc. (Specify	')				City or Town	, State)		
	pspite hours unara y fille		29a. Certifier XX Carriying	Physician: To the be	st of my know	wledge, deat	h occurred at the	time, date ar	nd place, ar	nd due to the ca	iuse(s) and m	anner as s	tated.
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director,	edical	опе)	xaminar: On the basis and manner	stated.	ion and/or in	vestigation, in my	opinion, dea	ath occurred				
	all .	Σ	29b. Signature and title of fertifier					ise number		29	9d. Date signe	ed (Month,	Uay, Year)
	6							570	028	I	DECEMBI	ER 07	, 2005
	Bj.			who completed cause o				21 ^	י אַ דּאָדַא	TC MD	21/01		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2005 December Joseph Charles 1045 AM Louch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Havre De Grace
If Under 1 Year | If Under 24 Hrs. Harre Itizens Home Hartord Nursing 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 2/15/1913 9. Birthplace (State or Foreign **Funeral** 215-03-7762 1√2 M 2 ☐ F 92 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" or "say injury or other traumatic aver: 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Be Completed by Funeral Director Harford Churchville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3053 Grafton Lane 21028 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anton Louch 2 Katrina Kraal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Stanley (Nephew) 2611 Wellworth Way West Friendship, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gdns. 12/13/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home Aberdeen, Maryland 21001-21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, any, leading to him ediats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by icate has been significate has been significated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Yes 2 certificate 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature a 29d. Date signed (Month, Day, Year) 30. Name and address description who completed cause of death (Item 23a) (Type, Print) 319 Sout Atras Avenue 32. Regerrar's Signature 31. Date filed (Month State 2005 Registrar

Joseph

			For State Registrer		f Marylan		artment of rtificate o				g. No.	05	Same and the same	23
	Physici	an	Decedent's Name (First, Middle,							2. Date of Death Month	Day	Yeer	3. Time of	
	/Medic	cal		ARLENE LA			4b. City, Town	or Location	of Dooth	DECEMBER	4c. County	2005	2:20	PM
	Examin	ıer	4a. Facility Name (If not institution, HARFORD MET				7.			ن <u>ا</u> ت			OD.	
	Funeral				7. Age (In yrs.	last birthday)	If Under 1 Ye		24 Hrs.	8. Date of Birth		IARFO 9. Birthp	olace (State o	or Foreign
	Director		084-42-6450	1 □ M 2 💢 F	55	Yrs.	Months Day	/s Hours	Min.	Nov 15,	1950	Cou	iry) Iew Yoz	ck
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	nation						0d. Inside C	the Limite
	sho	5			100.01	y, rown or Lo						1		2 🗆 No
	the N	Director	Maryland I	Harford			Havre 10f. Zip Code	e de G	race	10	g. Citizen of \	What Cour		
	3a or		462 Battery	/ Drive					1078		•	USA	,	
	death	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13.	Was Decedent of			ecify Yes or No- Rican, etc.)		e - Americ	can Indian,	
ဖွ	d within 72 hours after death with the Maryland jiene. jiene. r than: "natural; or items 23a or 28a-f show tre Madical Examiner must be mulliand at the Madical Examiner must be mulliand.	T.	1 Never Married 2 Marrie	Armed Fo ed 1 ☐ Yes If Yes, Giv	2 X No		1 Yes, specity C 1 □ Yes 2 <b>X</b> N			rican, etc.)	Specify	ck, White,		
8	ural',	d by	3 X Widowed 4 ☐ Divorced	Year or D	ates:								.ack	
21215-0036	"natu	Completed	15. Decedent' (Specify only highes			(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during mo:	st of work	ing 1	6b. Kind of B	usiness/ln	dustry	
12	within ene. than "	duc	Elementary/Secondary (0-12)	College (1	1-4or 5+)		ensed Pi	•	al Ni	irse		Hosp	ital	
g 5	in the Hyg	Be C	17. Father's Name (First, Middle, L	ast)						e (First, Middle, M.			LCAL	
Maryland	o c to to	To B	William Land					Ve	era A	dkins				
ary	and s m		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Stre	et and Numb	er or Run	al Route Number,	City or Town,	State, Zip	Code)	
	1 and 2 Health em 27 i		Na-imah Armste	ead / daug	<del></del>					erdeen,				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from	State	emetery, crei	sition (Name of natory or other p	olace)			Oc. Location -	•		
Ë	tment: tant:		`4 □Donation 5 □ Other (Sp		RC		Cemete			9/05 I	inden,	New	Jerse	У
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	licensee		22	Name and Add Li 55	sa Sco Lew	ott F is St	uneral H reet, Ha	ome, P vre de	.A. Grac	re. MD	21078
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the deat	h. Do not ent	er the mode of o	tying, such as	s cardiac	or respiratory arres	st,		Approximat Interval Bet	e ween
	Pnysician		Immediate Cause (Final disease or condition	_a	una (	anci	ON .						Onset and I	Jeath
	/Medical Examiner		resulting in death)	Due to	(or as a crinseq	uence of):						(	)	160
	_xammo.	<u></u>	Sequentially list conditions,	b. — Due to	or as a consen	metrice of).						1	en n	LOVUM
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	dequentially list conditions, any, leading to immediate use. Enter Underlying suse. Enter Underlying suse use rulpury at initiated events.  5. Due to (or as a consequence of):  3. 6 m mms.										
<u>,</u>	be executed siclan and burial-transit	Еха	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							*	
8760,	ate be executed hysician and the burial-transit			d										
9	ntifica ng ph	Med	IF FEMALE:											
Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregna pirth 2  Feta	ıl death 3 🗀	Ectopic pregna					te of delive	,	Year
о. В	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/Medical	1 Yes 2 No	4☐Pregn 9☐Unkn	nant at time of d own	leath 5	Other (specify)	)			1010	*****	Duy	- Gai
<u>α</u>	that the ed by detac		Part II. Other significant conditio	ns contributing to d	eath but not res	ulting in the u	nderlying cause	given in Part	I.	23e. Did toba	cco use cont	ribute to tl	ne cause of c	leath?
ds,	uires signi	d by	Breast Co	incer.	Heavt	freille	18.			1 🔁 🖽	2 □ No	3 Prob	ably 4 🗆	Jnknown
COL	w requir been si should	lete	Horiti	tino	mend	190m 18	na Hay			24a. Was an	24b. \	Were auto	psy findings	available
of Vital Records,	The lav	Completed	- Figure		, cara	001790	parring	*		autopsy perform	ed? (	orior to co death? I 🔲 Yes	psy findings mpletion of c	ause of
ta		O.	25. Was case referred to medical					26. Plac	e of Deat	1 ☐ Yes 2! h (Check only one		162	20110	
<u> </u>	ystcia ils cer direct	ToB	examiner? 1 ☐ Yes 2 ☐ NO	Hospital: 1 🖸	Impatient 2	ER/Outpatier	nt 3□ DOA	Other: 4 🗆 N	ursing Ho	me 5 Residen	ce 6 □Oth	er (Specif	y)	
	ding Ph h. After thi funeral		27. Mann → Death  1 ■ latural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		njury at Vork?		28d. Describe hov	v injury occur	red		
Sio	uttendi death. ctor: A r the fu	cati	2 Accident investig	01 50	NIA			☐Yes 2 🖯	TNo	00/ Latia- /Ct	-4 ( 4 ( 1)			-
Division	l or Attend after death Director: ,	Certification:	4 Homicide determi	ned 286. Place buildi	of Injury - At he ing, etc. (Specif	ome, tarm, str	eet, factory, office	ce		28f. Location (Stre City or Town,		er or Hura	u Houte Num	per,
_	spital ours a		29a. Certifier 1 Certifyin	p Physicien: To the	best of my kno	owledge, deat	n occurred at the	time, date a	nd place.	and due to the cau	ise(s) and ma	inner as s	tated.	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical		examiner: On the b										)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	0			29c. Lice	ense number		29	d. Date signe	d (Month,	Day, Year)	
)			Van l	115	- 1	00	BK	935	635	55	12/0	×4/2	2005	
	10		30. Name and address of person	who completed caus	se of death (Item	п 23а) (Туре,	Print)	C. Al.	1 .	Λ.				
	W		Harford N	emonal	HOSPIT	RUL	201	Journ	Uni	on Huer	Me			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 0 7 2005	1 32. H	Registrar's Signa	boule	,							
		-	DEO 0 1 5000	THE WAY	50									

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

ODIGINAL

Sports

32. Registrar's Signature

			For State Registrar	State of I	Marylan		artment of I				711115	41425	
_		35	Decedent's Name (First, Middle,	Last)			timouto or	Dodin	2. Da	Reg. ate of Death	NO:	3. Time of Death	
	Physici		Justina	Lewis						onth CEMBER	Day Yea 13, 200		М
١.	/Medic Examin		4a. Facility Name (If not institution,		er)		4b. City, Town, o	or Location of			4c. County of De		_
			St. Mary's	Hospital			Leon	ardto	wn		St. Ma	arv's	
F	Funeral		5. Social Security Number 6	5. Sex 7. 1 ☐ M 2  F	Age (In yrs. I		If Under 1 Year Months Days	If Under		ate of Birth fonth, Day, Ye		Birthplace (State or Foreig Country)	gn
	Director		056-09-1111	1 M 2	90	Yrs.					915	New York	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limit	ts
	/aryli	ō	) 1 1 0·	× 1				1				1 ☐ Yes 2 N	
	28a-	Director	Maryland St.  10e. Street and Number	Mary's			HOLI 10f. Zip Code	.ywood		100	Citizen of What	Country?	
	n 72 hours after death with the Maryland "natural", or liems 23s or 28a-f show galical Examinat must be notified at	٥	44827 Contrail I	) and			2063	6		100			
	ms 2:	Funeral	11, Marital Status	12. Was Decede		S. 13.1	Was Decedent of I f Yes, specify Cub		gin? (Specify Y	es or No-	14. Race - Ar	1 States merican Indian,	
9	or Ite	Ē	1 Never Married 2 Marrie						n, Puerto Rican,	, etc.)	Black, W	·	
215-0036	ral', c	d by	3 Midowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2 ■ No	Specify:			Specify: Wh	ilte	
<del>ر</del>	72 h	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup	during most	t of working	16b	. Kind of Busine:	ss/industry	
	han.	Idu	Elementary/Secondary (0-12)	College (1-4	or 5+)		OO NOT use retire	d)					
2	filed within Hygiene. Ither than "		17. Father's Name (First, Middle, La			Но	memaker	10 Metho	er's Name (First	Middle Mail	Own Ho	ome	
anc	be d o	Be		,				18. MOUTE					
Ž	should be filed within ind Mental Hygiene. s marked other than ' umatic event, Tre Me	To	Michael Ang			10h Mailie	a Address (Ctrasi	and Number			nervini	To Code	
Maryland 2	nd 2 sho alth and 27 Is mu r trauma						Gantas (Street						
	1 a Heg		James Lewis /	Son	20b. PI	ace of Dispo	Contrai sition (Name of		a, Holl Date		Mary Lan Location - City		
õ	0 0		1 ■ Burial 2 □ Cremation 3  1 ■ Donation 5 □ Other (Spe		II.		natory or other pla	1	10 17 0				
Baltimore,			21. Signature of Funeral Service Li			James	Cemeter	y ss of Facilit	12-1/-2	005 Lex	kington	Park, MD	_
Ä	permit. Departr Importa eny inji		Kyle S. Sin	Trace	01206	122	055 Holl	mood	Brinsi	ield Fi	ineral H	Home, P.A. ID 20650-027	7.0
8760,	death certificate be executed e attending physician and for use as the burial-transit	Immediate Cause (Final disease or condition resulting in death)  Section field list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Approximate Interval Between Onset and Death		
O. Box 6	at the death certifica by the attending ph tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 ☐ Fetal t at time of de	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of c Month	delivery Day Year	
Vital Records, P.	The law requires that the tee bas been signed by the bage 2 should be detache	by	Part II. Other significant condition	s contributing to deat	but not resu	ilting in the u	nderlying cause giv	ren in Part I.	. 23		_/	to the cause of death?  Probably 4 Unknow	'n
000	s bee	Completed		, ,	,				24	ta. Was an	24b. Were	autopsy findings availabl	le
Ä	The lav	mc								autopsy performed	?/ death'	o completion of cause of	
ta		Ö	25. Was case referred to medical		_			26 Place	of Death (Chec	Yes 2	No 1 Y	es 2 No	
	ysician: s certific director.	To B	examiner? 1 Yes 2 No	Hospital:	atient 2 🗆 E	ER/Outpatien	t 3 DOA Oth	200			6 □Other (Sp	necify)	Т
0	g Physer this seral di		27. Manner of Death	28a. Date of I		28b. Time of	28c. Inju	y at		escribe how in		, bully,	Ħ
0	vttendin death. ctor: Aft y the fur	atio	1 Natural 5 Pending 2 Accident investiga	tion	buy / bui/	mjory		Yes 2 1	No				
DIVISION OF	or A	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 289. Place of	Injury - At hore etc. (Specify	m <b>e,</b> farm, str	et, factory, office		28f. Lo	cation (Street ty or Town, St	and Number or l ate)	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the be caminer: On the basis and manner	s of examinati	vledge, death ion and/or inv	occurred at the tirestigation, in my o	me, date and opinion, deat	d place, and du th occurred at th	e to the cause he time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and the of certifier				29c. Licens			29d. l	Date signed (Mo	nth, Day, Year)	_
			· /~	~			Do	062	313	] 1	-/14/ -	5	
-	m		30. Name and address of person w	no completed cause o	of death (Item	23а) (Туре,	Print)	^					
_	10		Suresh Patel, M				h_Road,	Høllyv	vood, Ma	aryland	20636		
4	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signat		~~~/			-			

DHMH 17 Rev 1/2001

JUSTINA LEWIS

			Please	State of Maryland /				-	_	
			For Stete Registrer	State of Maryland	-	icate of L			2 0 0 5	41426
	7%		negistrer     Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h	3. Time of Death
	Physicia		William Porter La	wrence				December	Day Year 200	NA NA
13	/Medic Examin		4a. Facility Name (If not institution, give		4t	o. City, Town, or	Location of Death		4c. County of De	
			Anne Arundel Medi	cal Center		Annapol:	Ĺŝ		Anne Ar	rundel
	Funeral	-	Social Security Number     6. Security Number	7. Age (In yrs. last b	М	Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
u	Director		410-44-3904	75	Yrs.			Jan. 13		nnessee
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Locati	on				10d. Inside City Limits
	daryli f sho	ō	Marraland Anna Am	um da 1 Crasson	11	_				1 ☐ Yes 2 ☐ No
	the t	Director	Maryland Anne Ar  10e. Street and Number	under   Crown	svill	10f. Zip Code		10	Og. Citizen of What (	Country?
	d within 72 hours after death with the Maryland Jiene. r than "natural", or lterna 23a or 28a-f show The Madical Examiliar rust be natified at		300 Kyle Road			21032		ī	Inited Sta	tes
	ma 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was		spanic Origin? (Sp n, Mexican, Puerto		14. Race - An	nerican Indian,
9	or Ite		1 Never Married 2 🔀 Married	Armed Forces?  1  Yes 2 If Yes, Give			Specify:	rican, etc.)	Black, Wh	
8	ral', c	t by	3 Widowed 4 Divorced	Year or Dates: 1951-199	36	Yes 2 No	Specify.		Specify: W	nite
5	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation = 15 de completed)	(Give kind	t's Usual Occupa d of work done o	uring most of work	ing	16b. Kind of Busines	s/Industry
12	within iene. than	m	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired,				
2	illed v Hygie other t		17. Father's Name (First, Middle, Last)	5+	Nava.	1 Office	18. Mother's Nam	e (First, Middle, M	U.S.Na Maiden Sumame)	ıvy
and	ed ita	Be C					Tennie		•	
2	2 should be and Mental Is marked o	ဥ	Robert L. Lawrence	Pype, Print) 1!	9b. Mailing A	Address (Street a			City or Town, State	, Zip Code)
Maryland 21215-0036	s t and 2 should f Health and Mer item 27 Is marke other treumatic		Diane Lawrence/ w		hoo was	1 - Dani		11- 200	21/22	
Baltimore,	s 1 ar if Hea item othe		20a. Method of Disposition	20b. Place	of Disposition	on (Name of ory or other place	Crownsvi	Date	20c. Location - City o	or Town, State
e E			1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		Cremato		-2005	Baltimore	MD
at:	그 문문을 .		21. Signature of Funeral Service Licen	588						al Home, Inc.
ä	Depa Impo any i		> 12 Scitt Ki	marsu						, MD 21401
			23a Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the death. Do	o not enter t	he mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
,	Physician	1	Immediate Cause (Final disease or condition	· Cerebrovasa	ular	Disease	,			Onset and Death
1.	/Medical		resulting in death)	Due to (or as a consequence					-	
	Examiner	. /	Sequentially list conditions.	b						
A-	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ce of):					
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequenc	e of):					
760,	te be executed ysician and e burial-transit	cal E		Dac 10 (01 43 4 00100440110	30 317.					
687	physics the	dic	`	_d						
×	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy					23d. Date of d	elivery
Box	atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal dea 4 Pregnant at time of death		topic pregnancy ther (specify)			Month	Day Year
O.	t the de by the stached	nysi	9 Unknown	9 Unknown						
٦,	s that ned b	by P	Part II. Other significant conditions of	ontributing to death but not resulting	g in the unde	erlying cause give	en in Part I.	23e. Did tot	acco use contribute	to the cause of death?
rd	w requires been sign should be							1 □ Ye	s 2 No 3	Probably 4 Unknown
တ္ထ	aw re	plet						24a. Was a autops		autopsy findings available ocompletion of cause of
Ä	The lav	Completed						perform	ned? death	es 2□No
of Vital Records,	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only on	θ)	
>	hysic this ce al dire	일	1 ☐ Yes 2 X No			3□ DOA Oth	4 [] Nursing Fit	ome 5 Reside	nce 6 Other (Sp	pecify)
n D	ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injun Work		28d. Describe ho	w injury occurred	
sio	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	204 Laurtina (Cr		Com I Courte Number
Division	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, tarm, street	, factory, office		City or Town		Rural Route Number,
u	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier Certifying Ph	ysicien: To the best of my knowled	dre death on	courred at the tre	ne date and place	and due to the or	ause(s) and manner	as stated
	To the Hospita within 24 hours To the Funeral completely filled	Medical		niner: On the basis of examination and manner stated.						
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (Mo	nth, Day, Year)
	- s - o		> John Holi	W, M.D.		D00	52824		December.	5,2008
			30. Name and address of person who	completed cause of death (Item 233)  LEY, 250 WOO	a) (Type, Pri	nt)			4	-
			JOHN M. McCy	PLEY, 250 WOO!	D ROX	D. ANA	VAPOLIS,	MD 21	402	
		ate	31. Date filed (Month, Day, Year)	32. Registral s Signature	1					
7	Regist	rar	DEC 9 7 2005	HORAL ST.	400					

			For 1 State	State of Ma	ryland / Dep	artment of H	lealth and M	ental Hygie	ne 2005	1.11.27
		-	Registrar	- 43	Ce	rtificate of	Dealli	Reg.(	No.U U U	9 1 9 C 1
18	Physici	an	Decedent's Name (First, Middle, L	as <i>t)</i>		100	Clai	2. Date of Death Month	Day Year	
	/Medic		Cameron			VIC	clain	December	05,2005	
	Examir	er	4a. Facility Name (If not institution, ga	ve street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
		- "	Johns Hopkins H			Baltimo			Baltimo	
	Funeral		Social Security Number     6.	Sex 7. Age 152tM 2□F	(In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Bir	thplace (State or Foreign ountry)
, and	Director		227-79-5456	102111	8 Yrs.			July 4, 1	997   Vi	rginia
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	ehor	_			Fairfax	ocation				1 Yes 22No
	8a-1	ctc	Virginia Fairf	ax	ralliax					
	ith th		10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23a	by Funeral Director	3314 Rocky Mount			22031			USA	
	ep .	ne	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Bleck, Whi	
36	or it	Y.	1 XNever Married 2 Married	1 ☐ Yes 2 📆 N If Yes, Give	0	1 ☐ Yes 2 ☒ No	Specify:		Specify:	•
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f ehow tha Madical Examinar must be notified at	q p	3 Widowed 4 Divorced	Year or Dates:					W	hite
5	72 h	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of workii d)	ng 16b	. Kind of Business	Industry
2	within ene. than	μ	Elementary/Secondary (0-12)	College (1-4or 5-	H)	N/A	a)		N/A	
C	ygien ygien t, th	ပိ	3			N/A		(5)		
pu	d oth	Be	17. Father's Name (First, Middle, Las					(First, Middle, Maid	den Sumame)	
<u>ya</u>	Men	2	John Clinton McC	lain, III			Amber Re			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the firm 27 ie marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship				and Number or Rura			
	1 and Health em 27 ther tr		John C. McClain,	III / Fath		Rocky Mo			, VA 22	
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other to		20a. Method of Disposition  1 Surial 2 Tycyemation 3	□ Bemovel from State	20b. Place of Disponentery, cre	osition (Name of matory or other plac	ce)	ate 20c	. Location - City or	Town, State
Ĕ	permit. Pages Department of the Important: If Ite any injury or of		4 Donation 5 Other (Spec	ify)	Everly	Crematory	12/11	/2005 A1	exandria	, Virginia
a	mit. Pa partmen portant: y injury		31. Signatur of Fureral Service Lice	ensee / AV.	V ( ) 2	2. Name and Addre	ss of Facility EV			
	Dep		MAN AUS	WILL	(1X) h 1	500 W. Br	addock Rd	. Alexa	ındria, V	A 22302
ĺκ			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that caused	the death Do not en	ter the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	Respir		cilure				Onset and Death
100	/Medical		disease or condition resulting in death)	u	consequence of):	CITOCIC				2 days
	Examiner			. Graf	1	host .	dispose			30 days
		ē	Sequentially list conditions, if any, leading to immediate	U.	consequence of):	1021	413010			73
	nsit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Arnit	e line	hoblast	ic leuk	emia		2 Vears
	al-tra	Xai	resulting in death) Last	Due to (or as a	consequence of):	10000	(000)	CVVIII		- /405
760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	cai Examiner		834						
687	phy:	_		d						
×	ding se a	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of de	divor
Box	atter for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3 [	☐Ectopic pregnancy ☐ Other (specify)	/		Month	Day Year
Ö	the d	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	3. 334	_ cd. (speey)				
P.0	that i	4	Part II. Other significent conditions	contributing to death bu	t not resulting in the u	ınderiving cause gıv	ren in Part I.	23e. Did tobaco	co use contribute t	o the cause of death?
ds,	ires that the death cer signed by the attendir d be detached for use	Completed by		•		, ,		t □ Yes	V	robably 4 □Unknown
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=	hysician: The law his certificate has b I director, page 2 s	S						1 ☐ Yes 2 🗓		s 2□ No
/ita	cian ertifi ector	Be	25. Was case referred to medical examiner?			1.00	26. Place of Death	(Check only one)		
=	Physi this c	ဥ	1 □ Yes 2 No	Hospital: 1 Inpatier			4   Nursing nor	ne 5 ☐ Residence	6 □Other (Spe	ecify)
	dter i	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Vate of Injury Month, Day	Year) 28b. Time o	Wor	rk?	28d. Describe how in	njury occurred	
sio	eath or: /	catl	2 Accident investigate 3 Suicide 6 Could not	ha			Yes 2 □ No			
Division of Vital Records,	irect irect	Certification:	3 Suicide 6 Could not determine		ry - At home, farm, st . (Specify)	reet, factory, office	1	28f. Location (Street City or Town, St		ural Route Number,
Ω	ital c	S		VI.			1			
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check only 2 Medical Ex	hysician: To the best of miner: On the basis of	oxamination and/or in	th occurred at the tire	me, date and place, a	and due to the cause ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	the Pin 24	led	one)	and manner star	ted.					
	To To	2	29b. Signature and title of certifier	HIKOD	1 1000	29c. Licens			Date signed (Moni	
•	(1)		> Inercal	melhi	www	mD	424012	De		05,2005
0	(3)		30. Name and address of person wh		ath (Item 23a) (Type	Print)	Street,	Dalli	o han	21207
1			Meredith Chuk	1		Wolte	street,	BRITIMON	c, IND	41481
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 7 2	32 Registra	r's Signature	وكانه				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 41428 State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2005 Dec. 9:34 P M Mary H. Mann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bowie Prince George's 9440 Merkel Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 17,1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ ¥F 84 Yrs. Mass. 020-16-8905 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Funeral Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 9440 Merkel Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Dowling Anne Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolina Beach, NC 28428 Mary Joanne Nobilio / daughter 310-2 Spencer Farlow Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 12/08/2005 | Silver Spring, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ung cancer 2-Months Due to (or as a consequence of) Due to (or as a consequence of).

**Physician** /Medical **Examiner** 

**Funeral** 

Director

ir then "naturel", or items 23s or 28e-f ehow the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel; or iten eny lojury or other traumatic event, the Medical Eventernance.

Baltimore, Maryland 21215-0036

death with the Maryland

attending physician and for use as the burial-transit

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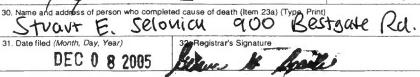
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medic 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physicien:

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year)



Annapolis,

?7 is marked other then "natural", or Items 23a or 28e-f shov traumatic event, the Modical Examinar must be notified at

within 72 hours after

. Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 is marked off

Department of Health a Importent: If Item 27 is any Injury or other trains once.

**Physician** /Medical Examiner

physicien and s the burial-transit

use as the attending for use as

signed by the a d be detached f

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within 24 hours after death

To the Funeret Director:
completely filled in by the

death,

To the Hospital within 24 hours at To the Funered D

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

Examine

Physician/Medical

Completed by

Be

Certification:

Medicai

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Merid items 10a, b, c, e, f, 11 per inf g851 1-4 State of Maryland, Department of Health and Menta	Il Hygiene	1.11.20
Cortificate of Dooth	2000	サーサムフ
Certificate of Death	Reg No.	

		1 - State Registrar		Ce	ertificate of	Death
/M		1. Decedent's Name (First, Middl	e, Last)			
	Physician /Medical	DETRON AN	DRE MACK			
	Examiner	4a. Facility Name (If not institution	n, give street and nu	mber)	4b. City, Town, o	r Location of Death
		Prince George's	Hospital	Center	Chever	1y
	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday		If Under 24 Hrs.
	Director	578-02-06/1	<b>Ж</b> [Ж]М 2□F	34 Yrs.	Months Days	Hours Min.

2. Date of Death 3. Time of Death <sub>27</sub>, 2ď05 10:40 P M November 4c. County of Death

Prince George's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

Usual Residence of Decedent 10a. State 10b. County MD. Frederick

10c. City, Town or Location Middletown Washington July 9 1971 Washington DC 10d. Inside City Limits

DC 10e. Street and Number

10f. Zip Code 3 Tile Silo Ct.

1 Yes 2 No 10g. Citizen of What Country?

2012 37tl 11. Marital Status

. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21769

Race - American Indian, Black, White, etc.

Specify: Black

To Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)

Baker

Private 18. Mother's Name (First, Middle, Maiden Sumame)

Harold Miles

Katherine Mack

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Katherine Mack Mother 20a. Method of Disposition

2425 25th St SE rm 216 Washington DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Washington National 12-7-2005 Cometery ame and Address of Facility Pope Funeral Home

20020

1 ☐ Yes 2 ☑ No

Suitland MD

Signatury of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

2617 Penn Ave SE Washington DC 20020

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Gunshot wound	of	head
Due to (or as a consequence of):		

Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day

9 Unknown

4☐Pregnant at time of death 9 Unknown

26. Place of Death Check only one

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

1 Tes

1 Yes

2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No

3 Probably 4 Unknown

Approximate interval Between Onset and Death

25. Was case referred to medical examiner? examineir 1 A Yes 2 ☐ No

27 Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation 11-27-05 6 Could not be

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28b. Time of Injury Found 22:03 A

28c. Injury at Work? 1 ☐ Yes 2 🕱 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred subject was shot

2 No

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4654 Hillside R Hillside RD SE DC

2 Accident

3 ☐ Suicide 4 Homicide

29c. License number

29d. Date signed (Month, Day, Year) November 28, 2005

29b. Signature and title of certifier

ho, mis

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

LING 31. Date filed (Month, Day, Year)

DEC 0 8 2005

111 Penn Street, Baltimore, Maryland 21201 2. Registrar's Signature

State Registrar

1	.31		1 - For State Registrar	State of M	Maryland		artment rtificate			and Mer		giene Reg. No.	005	414	30
		#	Decedent's Name (First, Middle, Last)							Date of Dea	ath		3. Time of	Death	
	Physici /Medi		Robert	H		Meye	r			1	Month ecembe	Day er 6.	Year 2005	1:05	A M
	Examir		4a. Facility Name (If not institution, g	rive street and number	or)		4b. City, T	own, or L	ocation o			7	County of Death		
	- Adjiiii	.01	National Luther	an Home			Roc	kvi1	le				ontgome		
	Funeral		5. Social Security Number 6	. Sex 7. /	Age (In yrs. las	st birthday)	If Under 1		If Under 2	24 Hrs. 8.	Date of Birt	į.	_	place (State o	or Foreian
	Director		270-10-0652	1 ▼M 2 □ F	93	Yrs.	Months	Days	Hours	Min.	Date of Birt (Month, Day (arch	79 .	1912 Cou	<sup>ntry)</sup> hio	
			Usual Residence of Decedent								- CII	2,	1742 0	IIIO	
	ylan		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	ity Limits
	Mar 1 st	tor	MD Montgo	mery	Rock	cville	2							1 TYes	2 🗌 No
	r 28g	Director	10e. Street and Number				10f. Zip (	Code				10g. Citiz	en of What Cou	ntry?	
	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "neturel", or Items 23e or 28e-1 show event. Ite Mcdral Exertible 1.	ī D	9701 Veirs Driv	7e				20	850			US	٨		
	ms 2	Funeral	11. Marital Status	12. Was Deceder		13. \	Was Decede			in? (Specify	Yes or No-		4. Race - Ameri	can Indian.	
10	fter of the result of the resu	Fur	1 □ Nøver Marriød 2 X Marriød	Armed Force 1 ☐ Yes 2 ☐		1	f Yes, specif	y Cuban,	Mexican,	gin? (Specify , Puerto Rica	an, etc.)		Black, White,		
33	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	_		1 ☐ Yes 2	X No	Specify:			3	Specify: Wh	ite	
21215-0036	2 hot	ed	15. Decedent's	Education		16a. Dece	lent's Usual	Occupati	ion			16b. Kin	d of Business/In		
15	in 72	Completed	(Specify only highest (			(Give	kind of work DO NOT use	done du	ring most	of working				,	
12	the iene	mo	Elementary/Secondary (0-12)	College (1-4o	r 5+)	0ua	lity	Cont	rol S	Suppor	t	Clex	veland (	Contro	1 c
0	filed Hygie other		17. Father's Name (First, Middle, La	st)						r's Name (F)					
an	d be ental	To Be	Theodore W. Mey	er				1	Martl	ha Hel	ms				
7	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the M	Ě	19a. Informant's Name/Relationship			19b Mailin	n Address /					r City or	Town, State, Zij	Code)	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Nancy Kaelber -							Rockvi				, 0000)	
e,	ges 1 and 2 t of Health If item 27 or other tre		20a. Method of Disposition	Daugneer	20b. Plac		sition (Name		ri. r	Date	TIE,		20850 ation - City or To	own State	
Baltimore,	0 0		1 🗆 Burial 2 🖰 Cremation 3		e cem	netery, cren	natory or oth	er place)	ı						
ţ	tme, rtent rjury		'4 □ Donation 5 □ Other (Spe		Met					y 12/		A1e	exandria	a, VA	
3al	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lic	ensee		22	. Name and	Address	of Facility	Hyson					
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П			23a. Part1. Enter the disease, or conscious shock, or heart failure. List on	inplications that caus ly one cause on each	ed the death. line.	Do not ente	er the mode	of dying,	such as c	cardiac or re	spiratory ar	rest,		Approximate Interval Bet	w <i>e</i> en
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9	g ph as th	edi													
Вох	eath certifi attending for use as	n/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								. 23	d. Date of delive	ery	
m	death a atte d for	Physician/Me	in the past 12 months?	4☐Pregnant	2 □Fetal de at time of deat		Ectopic pred Other <i>(sped</i>						Month	Day 1	/ear
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ds.	uires rign lid be										1 □ Y	es 2 🗹	No 3 Prob	ably 4 🗆 L	Inknown
Ö	w requir been s should	ompleted									24a. Was an 24b. Were			autopsy findings available	
Rei	has has	g E								- 1	autop:	sy	prior to co death?	mpletion of ca	ause of
Vital Records,		O										2 🔼 No	1 ☐ Yes	2□ No	
<u>Ş</u>	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:						of Death (Cl					
o	Phys this al dir	2	1 Yes 2 No	1 Inpa		VOutpatient			4 (A)Nui:				Other (Specif	y)	
'n		Certification:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of In (Month, E	ay Year)	3b. Time of Injury		c. Injury a Work?			Describe h	ow injury	occurred		
sic	Attending r death. ector: After by the fune		2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ba			М		s 2 N						
Division	l or At after o Direc	riii	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ice 28f. Location (Street and Number or Rural Rout City or Town, State)					il Route Numi	oer,
	To the Hospitel or Al within 24 hours after To the Funerel Direc completely filled in by				<u></u>					1					
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	To the leading 24		UNO)	and manner	stated.										
	vitl To	~	29b. Signature and title of certifier	16h -	20.0			License n		_			signed (Month,	r	
•			Muerte A	- 3	no		D	005	11 5	8-		DEC	EMBER	6 20	05
)	(4)		30. Name and address of person wh	o completed cause of											
-	0		VATTIT - ANDTONY	9701	VEI		MINE		SLOC	KUIL	LLU	H	0 208	50	
	Sta		31. Date filed (Month, Day, Year)	2. Regis	trar's Signature	0	700		,						
÷	Registr	ar	DEC. 0 8 20	JO Down	1	A	20								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Laura Lee Meyers December 2005 /Medical 3 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Dorchester ambridge 00 General If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) DoB **Funeral** Days 1 □ M 2 🖾 F 51 218-66-4650 Yrs. Washington, Director 3,1954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Dorchester Directo Maryland Madison 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1250 Old Madison Road 21648 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1 1 Carpenter s 1 and 2 should be filed w f Health and Mental Hygier Item 27 Is marked other th Home Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Samuel Lumsden Marjorie Anne Heritage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If Item 27 Is
eny Injury or other treu Harvey Cheezum/Companion 1250 Old Madison Road, Madison, MD 21648 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 12/4/2005 Delmar, Delaware 21. Signature of Fureral Service Lice 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Orrhosis Privsician /Medical Due to (or as a consequence of): **Examiner** Depsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of). Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitel or Attending P24 hours after death.Funerel Director: After t Certification; 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \) Homicide 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Byrn St. Cambridge, MO

3. Time of Death

9. Birthplace (State or Foreign

White

21631

Day

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 Yes 2 No

545M

Year

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of p

Eric

29b. Signature and title of certific

29a. Certifier

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Pri

To the within 2.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5

L	-	4	3	1

	1	State Registrar	,	C	ertificate of	Death	Reg	. No.	0 0	1170		
Dhuninin		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day	Year	3. Time of Death		
Physicia /Medica		ELIZABETH P. MC	LL				DECEMBER		005	2:50AM M		
Examine		4a. Facility Name (If not institution, ga				or Location of Death		4c. Count	y of Death			
		WILLIAM HILL MA				STON			TALBO'			
Funeral Director		218-40-6157	Sex 1 ☐ M 2 F 7. Age (In yrs. 91	last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JUN 27 1	91 <sup>1</sup> 4	9. Birthp	lace (State or Foreign		
and	-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or	Location				1	0d. Inside City Limits		
Mary	ō	MD TA	LBOT	E	ASTON					1 X Yes 2 □ No		
death with the Maryland ms 23e or 28e-f show fmust be notified at	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of	What Coun	itry?		
38 o		501 DUTCHMANS I	ANE			21601			USA			
deat	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 1	3. Was Decedent of h	Hispanic Origin? (Sp	ecify Yes or No-		ce - Americ			
urs a	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No		rricari, otc.)	Speci	ack, White, fy:	HITE		
d within 72 hours at giene. sr then "naturel", or	Completed	15. Decedent's I (Specify only highest g		(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retire	during most of work	sing 16	6b. Kind of E	Business/Inc	dustry		
1	m d	Elementary/Secondary (0-12)	College (1-4or 5+) <b>2</b>		NTIQUES DI	•		ANT	LQUES			
		17. Father's Name (First, Middle, Las			KITQUES DI	T	e (First, Middle, Ma					
0 0 5	To Be	FRANK POOL				BESSIE			,			
should nd Men marke umatic	Ĕ.	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street	and Number or Rui	al Route Number. (	City or Town	. State. Zip	Code)		
and 2 shoul saith and Min 27 ie marliner treumati		CHRISTINA DENGAT			9 EAST DEI							
s 1 ag f Hea item othe		20a. Method of Disposition	20b. F	Place of Dis	position (Name of rematory or other pla			c. Location				
permit. Pages 1 and 2 should b Department of Health and Menti Importent: If item 27 ie marked any injury or other treumatic e once.		1 Burial 2 Cremation 3	ify) CH	ESAPE	AKE CREMAT	TION CTR				ILLE, MD		
permit. Departr Importe any inje		21. Signature of Funeral Service Lice	Ostaxuslu CFS	P	22 Name and Addre FELLOWS, I 200 S. HAI	ELFENBEII RRISON ST	& NEWNAL	M FUNI	ERAL E	IOME PA		
(Cafe)	7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate										
Physician		Immediate Cause (Final	y one cause of Facri line.		(					Interval Between Onset and Death		
/Medical		disease or condition resulting in death)	aDue to (or as a conseq	mence of):	a.					19.		
Examiner				,								
	Je.	Sequentially list conditions, if any, leading to immediate	Sequentially list conditions, land, leading to immediate ause. Enter Underlying Sause (Uisease or mury hat initiated events									
cuted	Examine	that initiated events							- 4			
cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):								
ate be hysici he bu	Cal	d										
ertificate be e ling physiciar e as the buri	Medical	IF FEMALE:							-			
7 77 00 1	~	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death	B Ectopic pregnanc	y			ate of delive	<u> </u>		
the a	/s	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ Other (specify)							Month Day Year		
res that the death igned by the atte be detached for	Completed by Physician	Part II. Other significant conditions	contributing to death but not res	culting in the	underlying cause an	ven in Part I	23e Did toha	cco use con	tribute to th	e cause of death?		
he law requires t has been signe ige 2 should be o	by	Vernly or al.		aning ar are	distribution of the second	ren in r art i.	1 ☐ Yes	~		ably 4 Unknown		
w require been signature	etec	All of	theosclere	•								
has has be 2 s	mp	Ceremal as	newsan	w			24a. Was an autopsy performa	24b.	were autor prior to con death?	osy findings available apletion of cause of		
n: The icate har, page							1 Yes 2	\$No	1 🗆 Yes	2 No		
	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	IED/C	Ott		h (Check only one)					
्रे के अपूर्व विकास	-	27. Manner of Death	28a. Date of Injury	ER/Outpat 28b. Time	BHIL 3 DOA	4 LETNUISING HO	ome 5 Residence			")		
th. After funer	ţ	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year)	Injun		rk?  Yes 2 □No		,,				
l or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At h	ome, farm,	street, factory, office		28f. Location (Street		ber or Rura	Route Number,		
spitel or A ours after nerel Dire filled in by	Certification;	4  Homicide	building, etc. (Specif	y)			City or Town, .	State)				
G 70 6 1	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
within 24 hose To the Fur To the Fur completely	Med	29b. Signature and title of certifier	and mariner states.		29c. Licens	se number	29d	. Date signe	ed,(Month, L	Day, Year)		
⊢ ≯ ⊢ ŏ		Moly	Ollo mi	>								
(		30 Name and address of person who	completed cause of death (Iter	n 23a) (Tvo	e Print)	27 41	/	201	0 3			
(2)		ANNUBA API	EN MO 2/	9 5	e, Print) Washing	stan St	Easton	MO	2/60	01		
Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		]						
Registra		DEC 1'2 2	005	# 2	book							

Moore

Yrs.

7. Age (In yrs. last birthday)

76

Min

4b. City, Town, or Location of Death

Leonardtown
If Under 1 Year | If Under 24 H
Months | Days | Hours | M

2. Date of Death Month

DECEMBER 13

8. Date of Birth (Month, Day, Year)

July 9, 1929

3. Time of Death

9:30 p

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 RNo

Maryland

Year

2005

St. Mary's

4c. County of Death

	>	0 1		Tod. State		100. Oity, 10	WIT OF LOCATION				Tod. Inside City Limits
	Mar	field field	ţō	Maryland St. M	arv's		Tall Ti	mbers			1 ☐ Yes 2 ☑ No
	h the	r 28g	Director	10e. Street and Number			10f. Zip		10g.	Citizen of What C	ountry?
	, wit	13a o		17834 River	Shore Driv	re.		20690	II	nited Sta	atec
	deet	ring.	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Deced	dent of Hispanic Origin? (Stry Cuban, Mexican, Pue		14. Race - Am	erican Indian,
9	after	or its		1 Never Married 2 Married				erry Cuban, Mexican, Puer 2■ No Specify:	to Rican, etc.)	Black, Whi	
93	72 hours after deeth with the Maryla	Fxa.	d by	3 Widowed 4 Divorced	Year or Dates:		TLI Yes .	2₩ No Specify;		Specify: V	√hite
5-0	72 h	natu	letec	15. Decedent's (Specify only highest g	Education rade completed)	16	(Give kind of wor	al Occupation of done during most of wo se retired)	rking 16t	o. Kind of Business	/Industry
Baltimore. Marvland 21215-0036	withIn	yiene. rr than "natural", or Itams 23a or 28a-f shoi the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		/Technician		Communi	cations
Ö	filed	수 를 ゼ	Bec	17. Father's Name (First, Middle, Las	st)		20201111		me (First, Middle, Maid		Lacions
<u>a</u>	od ble	10 G	To B	Charles Edwa	ard Moore			Elsie	Elizabeth (	Grierson	
2	should	f Health and Men Itam 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19	9b. Mailing Address	(Street and Number or R			Zip Code)
Σ	and 2	= 2 ±		Doris V. Moo	ore / Wife		P.O. Box	88, Tall Ti	nbers. Mar	vland 206	90
re	98 1			20a. Method of Disposition  1 Burial 2 Cremation 3	□ D	20b. Place	of Disposition (Nan	ne of		. Location - City or	
Ĕ	Pag			`4 □Donation 5 □Other (Spec		Brins	field-Ech	ols Cre 12-	15-2005 CI	narlotto	Ho11 NO
<u>=</u>	permit.	Department important: any injury o		21. Signature of Funeral Service Lic	ansee	Since	22. Name an		rinsfield I		
	ä	O E % S		Kyle S. Simo	ons	M0120	6 22955 H	ollywood Roa	id. Leonard	ltown. MD	20650-0279
- 1				23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause one ach lir	the death. Do	o not enter the mod	e of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	PI	ıysician		Immediate Cause (Final disease or condition	Sel	17875					Onset and Death
		Medical		resulting in death)	Due to (0)	a consequence	e of):				
- 1	<b>E</b> .	xaminer		Sequentially list conditions	D	eum					
	D	## ## ## ## ## ## ## ## ## ## ## ## ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence					
	ecute	and trans	Examiner	that initiated events resulting in death) Last	c	nwy	, , , ,				
ORE 68760.	X9 90	physician and s the burial-transit		roduling in doddin Eddi	Due to (or as	a consequence	e oi):				
RE 87	cate	ohysi the b	dlca		d						
00W	ertific	attending ph for use as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy			-		
H ⊠	eath c	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant at	2 Fetal dea	th 3 Ectopic pro			23d. Date of de Month	livery Day Year
ELLSWORTH MOORE ords, P.O. Box 687	requires that the death certificate be executed	ed by the detached	Physiclan/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	lime or death	3 □ Other (sp	9CIIY)			
MO M	that	ed by detac	/ Ph	Part II. Other significant conditions	contributing to death be	ut not resulting	in the underlying o	use given in Part I.	23e. Did tobacc	co use contribute to	o the cause of death?
LSV.	uires	been signe should be	q p	Part II. Other significant conditions	Hrten	9 0	disease		1 ☐ Yes	2 □ No 3 □ P	robably 4 Junknown
ND ELL Record	W Fed	shou	Completed by	Covorany	via	7			24a. Was an	24h Were at	utopsy findings available
Ne Ne	The law	ate has page 2 s	dmo						autopsy performed	prior to death?	completion of cause of
ROLAND Vital Re	ician: T		ပိ	25. Was case referred to medical				00 01	1  Yes 2	No 1 □ Yes	2 No
RG Ki	icia	certifica rector, p	ä	examiner?	Hospital:			Other	ath (Check only one)		

Hospital: 1 Hipatient

28a. Date of Injury (Month, Day Year)

son who completed cause of death (Item 23a) (Type, Print)

32. Regist

DEC 1 5 2005 >

Ellsworth

1 - For State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

6. Sex

1**個** M 2□ F

Roland

5. Social Security Number

220-26-6298

Usual Residence of Decedent

					-	
ancy //		-		ate of de	Blivery Day	Year
e given in Part I.		d tobacco			o the caus	se of death?
	24a. Wi au pe 1 🗆 Yes	topsy rformed?		Were a prior to death?	completic	dings available n of cause of
26. Place of De	ath (Check onl	v one)				
Other: 4 Nursing	Home 5 □ Re	sidence	6 🗆 Ot	her (Spe	ecify)	
Injury at Work? 1 □ Yes 2 □ No	28d. Describ	e how inju	ury occu	irred		
fice	28f. Location City or 7	(Street a own, Stat	nd Num te)	ber or A	ural Route	Number,
ne time, date and place my opinion, death occ						use(s)
cense number		29d. Da	ate sign	ed (Mon	th, Day, Y	ear)
17000		12	,	11.	17	

Registrar

Certification:

5 Pending

investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier (Check only one) 29b. Signature and ti

4 Homicide

30. Name and address of

31. Date filed (Month, Day, Year)

Manoj Panwala, M.D.,

DHMH 17 Rev 1/2001

Division of Vital Records,

Hospital or Attending Physician:

After this

within 24 hours after death. To tha Funarai Diractor: A completely filled in by the fu

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, water and passed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.

Injury

28c. Injury at Work?

5502

37767 Market Drive, Charlotte Hall, Maryland 20622

			Pied  For State Registrer	State		ind / Depa		of H	ealth	and N	_			ible.	and a	34
	Physic /Medi		1. Decedent's Name (First, Middle Mary Elizabeth	McKnight							2. Date of I Month Decem	Death	Day 2	Year 005	3. Time	of Death
	Examir	ner	4a. Facility Name (If not institution College View Co	enter			4b. City, To	erio	ck				Fred	y of Death ericl	C.	
	Funeral Director		5. Social Security Number 214-32-4390 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of E (Month, April	Birth Day, Ye	1933	COL	place (Statentry) yland	_
	Maryland	tor	10a. State 10b. County Maryland Frede			City, Town or Lo									10d. Inside	City Limits
	th with the 23a or 28 Ist be not	Funeral Director	10e. Street and Number 4 East 13th Str	eet			10f. Zîp C 2170							What Cou Stat		
980	n 72 hours after death with the Maryland "natural", or items 23a or 28e-f show solical Examiner must be notified at	b	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Strivorced	ried Armed F	2 ☑ No iive		Was Deceder If Yes, specification 1 Yes 25		spanic Or n, Mexica Specify		ecify Yes or i Rican, etc.)	No-	Bla	ce - Amen ck, White, by: Whit		
21215-0036	within ane. than *	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12		(1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d retired)	ition <i>luri</i> ng mos	st of work	in g		Kind of E	Business/In	ndustry	
land 2	be filed ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Carl Thompson,			Dairy	7 Farme				e (Fîrst, Midd onebur	le, Maic				
, Maryland	nd 2 alth ar	-	19a. Informant's Name/Relations Charlene Snyde:	hip (Type, Print)		9201	Catoci	Street a	n <i>d Nu</i> mb	er or Rura	Hwy,	ber, Cit	leric	k, MI	217	702
altimore,	t. Page rtment o rtant: If		20a. Method of Disposition  1	ipecify)	State	Place of Dispo cemetery, crer	natory or other	er place eter	у	12/8	/2005	Fre	ederi	ck, M	own, State	
Ba	Depa Impo any ir		Frolly &	(m)		16	21 Opc	ssu	ımtow	n Pi	uffer ke, Fr	edei			21702	
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or leart dilure. List Immediate Cause (Final disease or condition resulting in death)	a. C.C	caused the deleach line.  2 ~ L ev (or as a conse	of	er the mode	Fl.	, such as		er respiratory		Ina	ng	Approxim Interval B Onset an	etween
	be executed sician and burial-transit	Examiner	Sequentially list conditions,	c	(or as a conse	·					***					
68760,		cai		d	(01 43 4 001100						-					
.O. Box	death certif e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	1 ☐Live	utcome of pregi birth 2 Te nant at time of nown	tal death 3	Ectopic preg Other (spec							te of delive	ery Day	Year
rds, P	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant condition	ons contributing to c	death but not re	esulting in the u	nderlying cau	se give	n in Part I					tribute to th	ne cause of	death? Unknown
of Vital Records,		Completed									24a. Wa aut per 1 Yes	opsy formed:	,	prior to co death?	psy finding mpletion of 2 \Brightarrow No	s available cause of
f Vita	nysicien: Thanis certificate director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DOA	Other			n <i>(Check only</i> me 5 ☐ Res		6 □Oth	er (Specif	y)	
Division o	Attending Physicien: r death. sctor: After this certifica	ertification;	27. Manuer of Death  1 Natural 5 Pendin  2 Accident investig	gation	of Injury oth, Day Year)	28b. Time of Injury	28c	Injury Work 1 🗆 Y	at		28d. Describe					
DIX	in the	O	3 Suicide 6 Could i	ined 266. Flac build	ling, etc. (Spec						28f. Location City or To	own, Sta	ate)			m <i>ber</i> ,
	he Hospital in 24 hours a he Funeral I pletely filled	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To th Examiner: On the b and mar	e best of my kr pasis of examin nner stated.	nowledge, death nation and/or inv	occurred at restigation, in	my opi	e, date an inion, dea	nd place, a th occurr	and due to the ed at the time	e cause , date a	(s) and ma ind place,	anner as st and due to	ated. the cause	(s)
•	To the I within 2. To the I complet	Z.	29b. Signature and title of certifier	r					number	17			Date signe		Day, Year)	

Registrar DHMH 17 Rev 1/2001

State

5

Johnson Dr., Frederick MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65-C Thomas 32. Registrar's Signature

Hemen shah, 65
31. Date filed (Month, Day, Yeer)
DEC 0 8 2005

			For State Registrar		S	•			Depa		t of H	Ensure lealth an Death	nd Me	ental Hy	giene Reg. No.	00	5 5	41435
	Physici /Medi		Decedent's Name     Mayna		le, Last) Shern	nan	Mu	llinix	2				2	Date of D Month Decen	Day	7, 2	.005	3. Time of Death  12: 22A
	Examir		4a. Facility Name (I	not institutio	n, give stre	et and nun	nber)					Location of E	Death		4c.	County	of Death	
	Funeral Director		Freder 5. Social Security N 218-38-3	umber	6. Sex			n yrs. last b	irthday) Yrs.	If Under Months		erick    Hours	Hrs. 8	Date of B			9. Birthp Mary	k lace (State or Foreig Tand
	D		Usual Residence of															
	/arylar f show	or	10a. State Maryland	10b. County Howar	_		10	oc. City, To Mount									1	0d. Inside City Limits 1 ☐ Yes 2 🎇 No
	with the Pie or 28a-	Direct	10e. Street and Nur 16721 Fr		k Roa	ıd				10f. Zip		771			10g. Citi		Vhat Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is markad other than "natural", or itams 23e or 28a-f show important: If itam 27 is markad other than "natural", or itams 28e or 28a-f show principly or other traumatic event, the Medical Exertil art must be rigitlified at once.	Completed by Funeral Director	11. Marital Status  1 XNever Marri 3 Widowed	ed 2□ Mar	12.	Was Dece Armed Fo 1 Tes If Yes, Giv Year or Da	rces? 2 DXNo ∕e	er in U.S.	1	Was Decect f Yes, spec 1 ☐ Yes	dent of Hi cify Cuba	ispanic Origin in, Mexican, F Specify:	n? (Spec Puerto Ri	fy Yes or N can, etc.)	0-	14. Race	e · Americ k, White,	etc.
21215-0036	within 72 ho ene. than "natur ne Medical	mpieted	Elementary/Seco				I-4or 5+)	16	(Give	tent's Usua kind of wor DO NOT us Labor	rk done d se retired	ation during most of f)	f working	1	Нот	ward	siness/Ind	dustry unty
	filed v Hygie thar t int, In	ပိ	7th 17. Father's Name		Last)					Labor	er	18. Mother's	Name (	First, Middle			rnmei	nt
Maryland	2 should be filed within 's and Mental Hygiene. Is markad othar than "raumatic evant, Inc Men	To Be	Sherman	Mayn	ard		inix	19	b. Mailír	ng Address	(Street a	A1t		Eliza Route Numi		G - 17.77	Annual Contract Contract	7.00
$\geq$	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or othar trai once.		Margaret 20a. Method of Dis	oosition Cremation	3 □Rem		1	20b. Place cemet	of Dispo ery, crer	sition (Nan	ne of ther plac	ick Ro metery	Da	te	20c. Lo	cation -	City or To	
Baltimore,	permit. Pa Departme Important any injury		4 □ Donation  21. Signature of Fu			26	1/1 11	mv	) M	Name and Diesw	d Addres	ss of Facility	ams	P.A.,	Fune	era1	Home	е
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68760,	cate be execute ohysician and the burial-tran	ā			( d													
P.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2 ( 9  Unknown	months? □No	23c.		oirth 2 [ nant at tim	pregnancy Fetal death		Ectopic pr Other (sp					2	23d. Dat Moi	e of delive	ry Day Year
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n of	ng Phys fter this neral di	on: To	1 ☐ Yes 2 ☐ 27. Manner of Deat 1 ☑ Natural	h 5 🗌 Pendi	ing	28a. Date	Inpatient of Injury th, Day Y	2 ER/C 28b	utpatier Time o Injury	1 2	28c. Injun Worl	y at k?	28	d. Describe				/)
Division	or Attanding F after death. I Diractor: After d in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could	igation I not be mined	28e. Place buildi	of Injury ing, etc. (	· At home, 'Specify)	farm, sti	M eet, factory		Yes 2 □ No	-		(Street and own, State)		er or Rura	l Route Number,
_	To the Hospitei or Attandii within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical Ce	29a. Certifier (Check only one)	1 € Certifyi 2 ☐ Medica	ng Physic I Examiner	ian: To the	asis of ex	camination a	ge, deat	n occurred vestigation	at the tim	ne, date and p pinion, death	place, an	d due to the	cause(s) , date and	and ma	nner as st and due to	ated. the cause(s)
)	To the within To the complex	Me	29b. Signature and	title of certific	er //	110	10	2		290	c. License	e number	99				(Month,	Day, Year) 2005
			30. Name and addi				se of deal	th (Item 23a 11we11	) (Туре, Dr:	Print)	Mou	nt Air	y, M	aryla	nd 2	2177	1	

State Registrar 31. Date filed (Month, Day, Year) DEC 0 8 2005

Ronald E. Miller M.D.,

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dec. 2005 5:47 a M Byron D. McAlister /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Annapolis
If Under 24 Hrs. 8. Anne Arundel Center Anne Arundel Medical 8. Date of Birth (Month, Day, Year) Mar. 3, 1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours 59 KY Director 403-62-9487 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

and: If item 27 is marked other than "naturel; or Items 23a or 28e-f show thy from the them and the numble own. Its Modes Examiner master on Littled at ury or other treumatic event. Its Modes Examiner master nutilined at 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Berrywood Drive 21146 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 XNo Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Manager MAPEI Corp. 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Duward McAlister Estelle Winstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Lee McAlister/Wife 105 Berrywood Drive, Severna Park, MD 21146 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Dec. 6 2005 permit. Page Department o Importent: If any injury or once. injury or Baltimore, MD Metro Crematory \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Domes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophagus **Physician** Cancer month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medicai as the l 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autops JNo 1 Yes or Attending Physicien: after death. Director: After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 1 Inpatient 2 □ R/Outpatient 3 □ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Deat 28c. 28d. Describe how injury occurred Certification: 5 Pending investigation 1 2 Vatural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D52830 December 1,2005 canine weiner mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP 900 Best gak Road #300 Annaplis, MD Jeanine Werner. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

			For State Registrar	1,10400	State o	f Maryla	nd / Dep	artme	nt of H	Health and Death		ntal Hy	giene Reg. No	UUU.		437
		П	1. Decedent's Name (I	First, Middle, La	ist)						2	. Date of De				e of Death
	Physici: /Medic		Clare	nce R.	Moore						1	Month	Da	1 200	5 5:	30 A.M.
	Examin		4a. Facility Name (If no	ot institution, giv	e street and nur	mber)		4b. Cit	y, Town, o	or Location of De	ath			. County of De	ath	
			Baltimor	e-Wash	nington	Med.	Ctr.	G	len	Burnie	9			Anne	Arund	el
	Funeral		5. Social Security Num		Sex 12XM 2□F		. last birthday)	If Und Months	er 1 Year Days	If Under 24 H	in. 8	. Date of Bir (Month, Da	th v. Year		irthplace (Sta	
	Director		218-01-234	44	1123.M 2LIF	90	Yrs.				(	Oct. 6	5, 19	915		MD
	and w		Usual Residence of De 10a. State	ecedent 0b. County		10c. C	ity, Town or Le	ncation							10d Inside	e City Limits
	Aaryli Sho	ō	MD		Arundel		.,,		vern	a Park						es 2 No
	the N	ect	10e. Street and Number						ip Code				10a Cit	tizen of What		
	with with	ī	339 Light		Avenue			101.2		146			109.01	USA		
	leath ms 2:	Funeral Director	11. Marital Status		12. Was Dece	edent Ever in I	U.S. 13.	Was Dec		dispanic Origin? an, Mexican, Pu	(Specif	fy Yes or No	)-	14. Race - Ar		1,
12 w	after or Itel	교	1 Never Married	2 Married	Armed Fo 1 Types If Yes, Giv	2 🗌 No					erto Rio	can, etc.)		Black, WI		
Z (03)	72 hours after death with the Maryland natural; or ttems 23a or 28a-f show Jical Examination notified at	l by	3 X Widowed 4 [	Divorced	Year or D	ve Wi ates:	WII	1  Yes	2 <b>X</b> No	Specify:			-	Specify:	White	9
NOP 24	72 h	Completed		5. Decedent's E	ducation ade completed)		16a. Dece	dent's Us	ual Occup	ation during most of v d)	workina		16b. K	(ind of Busines	s/Industry	
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	led w tygies her ti nt, th	ပိ	17. Father's Name (Fir	not Afiddle Lee	41			. L uck	Dri		lama (1	Fire A Adiabate	1	Local	55/	
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ARENCE Maryl	d 2 sl th an 7 is r traur		William 3			Son-in				and Number or Pasad			er, city o		, Zip Code)	
Je je	1 an Heal Hem 2 Hem 2		20a. Method of Dispos		,	20b.	Place of Dispo	sition (N	ame of		Date			ocation - City of	or Town, State	)
I OII	ages ant of t: If it		1 🔀 Burial 2 🔲 0 `4 □ Donation 5 l				cemetery, cre. Veter:				c. (			ownsvil		
CLAKENUE Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exament must be rediffed at once.		21. Signature of Funer		7	1				<b>-</b> ,	200					
B	permit. Departr Imports any inje		1 ome	STON	PAV	mis	E	Barra	nco (	& Sons, Ritchie	P.A	. Seve	erna	Park 1	Tunera.	L Home
			23a. Part1. Enjer the shock, or/heart fa	disease, or com	iplications that c	aused the dea	ath. Do not en	ter the mo	ode of dyin	ng, such as card	iac or re	espiratory a	rrest,	Park,	Approxir	nate
	Physician		Immediate Gause (Fin		~ )		1.1	1	` ^	3		0'		0		Between nd Death
	/Medical		disease or condition resulting in death)	-		om (or as a conse	quence of):	cm	- 1	ורטייוות	Sant.	as	636		10	year
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Вох	atten for u	cian	23b. Was decedent pr in the past 12 mg	onths?	1 Live b	irth 2 Fet	al death 3	Ectopic Other (	pregnancy	/				23d. Date of d Month	elivery Day	Year
P.O.	that the de ad by the detached	ysi	1 □ Yes 2 □ N 9 □ Unknown	10	9☐ Unkno			(-	,,,,,,							
<u>σ</u>	es that gned b be deta	by Pi	Part II. Other significa	nt conditions	contributing to de	eath but not re	sulting in the u	nderlying	cause giv	en in Part I.		23e. Did to	obacco i	use contribute	to the cause	of death?
rds	quires in signi uld be			1.74	··-						_	A	Yes 2	□ No 3 □ 1	robably 4	□Unknown
00	s been si	ojet										24a. Was		24b. Were	autopsy findin	gs available
Re	The lav	Completed									-	autop perfo 1  Yes	osy rmed?	death?	completion of s	of cause of
ta	ician: Th certificate rector, pag	۵	25. Was case referred	to medical	-					26. Place of D	eath (C		/		2 2 140	
>	ysician: is certific director,	To B	examiner?	)	Hospital:	inpatient 2	☐ ER/Outpatier	nt 3 🗆 🗆	Oth Oth					6 ☐ Other (Sp	ecify)	
0	ding Phy h. After thi funeral o		27. Manner of Death	5 Pending	28a. Dite (Mont	f Injury th, Day Year)	28b. Time o	f	28c. Injur Wor			d. Describe h				
<u>Ö</u> .	uttendir death. ctor: Al y the fu	atic	2 Accident	investigation				М		Yes 2 □ No						
É	or Att	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place	of Injury - At h ng, etc. (Spec	nome, farm, str ify)	reet, facto	ry, office		28f	Location (S City or Tox	Street an vn, State	nd Number or I e)	Rural Route N	u <i>mb</i> er,
	To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 11 (Check only 2[	Certifying P	hysicien: To the miner: On the ba	best of my kn asis of examin ner stated.	nowledge, deat nation and/or in	h occurre vestigation	d at the tin	me, date and pla pinion, death oc	ice, and	due to the at the time,	cause(s) date and	) and manner a d place, and du	as stated.	e(s)
	To the within 2 To the complet	Me	29b. Signature and title	e of certifier				2:	9c. Licens	e number			29d. Da	te signed (Moi	oth, Day, Year	)
	r s r ö		) A	61		mo			DU	3977			1000	mhar	12	200
			30. Name and address	person who	completed caus	e of death (Ite	m 23a) (Type,	Print)	- 1	3//	0		- CC	101	1 2-	
			anks V	Theren	18.5	1/23	when	20	We /	alin	JU	mi	·V	s an	1061	4
	Sta Registr		DE Date filed (Month,	*	005 32.	égistrar's Sign	arture A	bord							-	

		For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artment o	of Healt of Dea	h and N th		giene Reg. No.	005	41438	
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/Medic	al	Gloria Medin				45 Ch. To		ing of Dooth	Dec.	2,	2005 County of Death	3:00 a	A
Examin	er	4a. Facility Name (If not institution, gi		)			wn, or Locati			40.			
Funeral		Genesis Elder  5. Social Security Number 6.		ge (In yrs.	last birthday)				8. Date of Bir (Month, Da	th	Anne	Arundel place (State or Foreig	חנ
Director		569-38-6457	1□M 2⊠F	79	Yrs.	Months D	ays Hou	rs Min.	Feb 6,	1926	00	TX	
pug A		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	s
Manyla f sho	ō		Arundel			erna P	ark					1 ☐ Yes 2 ☑ No	
r 28a	rect	10e. Street and Number				10f. Zip Co				10g. Citiz	zen of What Co	intry?	_
th with	Funeral Director	409 Idleoak Cou	rt				21	146			USA		
r deal	iner	11. Marital Status	12. Was Decedent Armed Forces		S. 13.	Was Deceden	of Hispanic Cuban, Mex	Origin? (Sp	pecify Yes or No Rican, etc.)	)- 1	14. Race - Amer Black, White		
36 s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1	15X Yes 2□			kican		Specify: Wh	ite	
21215-0036  a within 72 hours after death with the Maryland gjene. gjene. then "natural", or flems 23a or 28a-f show the Madical Exertinant by notified at	edt	15. Decedent's E			16a. Dece	dent's Usual C	ccupation			16b, Kir	nd of Business/I	ndustry	
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FIG. Maryland 21215-0036  Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If term 27 is marked other than "natural", or Hems 23a or 28a-f show other traumatic event, the Medical Exactions to incitif of a		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of		Date		cation - City or 1		
Pages ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec		9 (		natory or other emator		Dec	005 <b>′</b>	Bal	timore,	MD	
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If ten 27 is marked oth any injury or other traumatic event once.		21. Signat re of Fun all Service		200	22	Name and A Barran	ddress of Fa	scility Sons,	P.A. Se	vern	a Park I	Funeral Ho MD 21146	me
reate be executed EXMINATION Create be executed EXMINATION CREATER STATES AND CREATER STA	lical Examiner	ock, or he of failure. List only a continuous continuou	a. ISC Due to (or a:  b. Due to (or a:  c. Due to (or a:  d.	HEW s a consequence s a consequence	uence of): uence of):	CAR	2010	MYC	PATH	4		Onset and Death	<i>f</i>
BOX 6 death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregr Other (s <i>pect</i> i				2	3d. Date of delin	very Day Year	
ecords, P.O law requires that the as been signed by th	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying caus	e given in P	art I.		obacco us	_	the cause of death?	1
~ · · ·	Completed								24a. Was autor perio 1 🗆 Yes		death?	opsy findings available ompletion of cause of	9
f Vital F ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?						lace of Dear	th (Check only o	one)			
of Vita Physician: this certific	P	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpatier		Other: 42	Vursing He	ome 5 Resi			ify)	_
ding F	io	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inj (Month, D		28b. Time o Injury	M 28c.	Injury at Work? 1 ☐ Yes 2	Z II No	28d. Describe	now injury	occurred		
Division  I or Attending after death. Director: After I in by the fune	ertification;	Z Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir	njury - At ho atc. (Specify	ome, farm, str				28f. Location (: City or To			al Route Number,	
Division or To the Hospital or Attending Phewithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical Ce	(Check only 2 Medical Exa	Physician: To the bes	of examina									
thin 2	Med	29b. Signature and title of certifier	and manner s	tated.		29c. L	icense numb	per		29d. Date	e signed (Month	Day, Year)	_
F 3 F 8		Di (1)	Wall.	· a	(P)	_	7311	3 C			-		
		30. Name and address of person who	completed cause of	death (Item		Print)	JJII.	J 0		7	المال المال	R 5,2005 May 2123	
Sta	to.	BRIAN C- W. 31. Date filed (Month, Day, Year)	ALLACE 32. As	trar's Signa	900 turg	5 KI	LBR	100	RD,	BAC	TIMORE	May 2123,	6
Registi			2005	m.	15 B	took)	8						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕽 🕽 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:31 A<sup>N</sup> 2005 December 2 Myren Ragnhild /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Hospital Months Days Hours Min. July 12,1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Illinois 1 □ M 2 🗓 F 75 Director 391-26-7187 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2√ No Purcellville Virginia Loudoun Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20132 e filed within 72 hours after death and Hygiene. <u>37271 Branch River</u> Road, Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give<sup>A</sup>
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Schools permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Important: If Item 27 is marked other tt any injury or other traumatic event, III.a. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Hanson Otto Oie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37271 Branch River Rd., Purcellville, Va. 20132 Delbert Myren/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Dec. 06, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Va. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MONEY & KING FUNERAL HOME, INC 171 W. Maple Ave., Vienna, Va. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) EMINAL AUTTE ANEL **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) Yes 2 No ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director Other: Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 1 Tes 2/12/No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ţ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Dec 00053864 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Richard A. Silva, MD

08

2005

31. Date filed (Month, Day, Year)

DEC

32 Registrar's Signature

9715 Medical Center Dr., #105, Rockville, Md. 20850

State of Maryland / Department of Health and Mental Hygienec 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Year **Physician** Meredith Edward Miller Sr. Dec. 8, 7:15 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4842 Old National Pike Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. B. Date of Birth Dec. 9. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**√**2 M 2□ F 77 220-26-0420 Director Yrs Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or Itams 23e or 28e-f show traumatic avant, the Medical Examinar must be notified at 10d. Inside City Limits MD Frederick Director Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4842 OldNational Pike 21702 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "rapy Injury or other traumatic avant, the Med once. county Elementary/Secondary (0-12) College (1-4or 5+) truck driver government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward N. Miller Marv Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Miller (Wife) 4842 Old National Pike, Frederick, MD21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/10905 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial Gardens Frederick, \* 4 ☐ Donation : 5 ☐ Other (Specify 21. Signature of Funeral Service Lic-Donald B. Thompson Funeral Home E. Main St., Middletown, MD 21769 cansed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. a. Part1. Enter he disease, or complications that shock, or he in failure. List only one cause of Approximate Interval Between Onset and Death Immedia Cause (Final disease or Cause (Final Priysician E/20 t-0 resulting in death) /Medical Due to (or as a consequence of): Examiner Ch-one Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9☐ Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Hospital: 1 Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🚜 No 2 ER/Outpatient 3 DOA this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) DIYGOC Drc 8+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederics DAUSES M9501 31. Date filed (Month, Day, Year) 32. Registras Signature Registrar

			1 _ State	ate of Ma		partment of e <i>rtificate o</i>	f Health and N		4000	4   4 4
	Physic	#	1. Decedent's Name (First, Middle, Last)	NIA CELE		ortineate e	Deam	2. Date of Dea		3. Time of Death
	/Medi Examir	cal	EARL ELLSWORTH  4a. Facility Name (If not institution, give stree			4b City Town	n, or Location of Death	NOVEMBE	R 29, 200	
7	Examin	ier.	GREATER BALTIMORE		CENTER	TOWSON			BALTIMOR	
3	Funeral Director		5. Social Security Number 6. Sex 220–24–0662 XX		(In yrs. last birthda 75 Yrs.	Months Day		8. Date of Birt (Month, Day JULY	y, Year) 30, 1930	Birthplace (State or Foreign Country) MARYLAND
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	with the Marylan s or 28a-f ehow be notified at	ctor	MARYLAND BALTIMORE		BALTIM	ORE				1 Tyes 2 No
	with the	Director	10e. Street and Number 8609 SILVER MEADOW L	ANTE		10f. Zip Cod 212			10g. Citizen of Wha	
	s after death v , or Iteme 23s	Funeral	11. Marital Status 12. V	/as Decedent E	ver in U.S.	. Was Decedent of	of Hispanic Origin? (Sp	ecify Yes or No-		American Indian,
36	within 72 hours after death with the Maryland ene. han "naturel", or Iteme 23e or 28e-f ehow he Medical Exantiner must be notified at	by Fu	1 Never Married XX Married 1	Yes 2 N Yes, Give ear or Dates:		1 ☐ Yes XX	Cuban, Mexican, Puerto No <i>Specify:</i>	rican, etc.)	2	VHTTE
×   5-0036	72 hou		15. Decedent's Education (Specify only highest grade con	n	16a. Dec	edent's Usual Oci re kind of work do	cupation ne during most of work tired)	ing	16b. Kind of Busine	
CV 21215	d within plene. r than	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5-	+)	. DO NOT use ret ANAGEMEN			CROCERY	BUSINESS
THE PERSON	ntal Hygined ad other event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumame)	DOSTNESS
- Jaryla	2 should be and Mental le marked o	<sup>L</sup>	WILLIAM NAGEL  19a. Informant's Name/Relationship (Type, F	Print)	19b. Ma	iling Address (Stre	EVA MAY eet and Number or Run		r. City or Town. Stat	re. Zip Code)
3 €	and salth		RUBY E. NAGEL/WIFE		1100	FREESTO	NE DRIVE,	WESTMIN	ISTER, MD	21157
	S to to		20a. Method of Disposition  The Burial 2 □ Cremation 3 □ Remove  4 □ Donation 5 □ Other (Specify)	al from State		ematory or other p	clace)   Z/	07/2005	20c. Location - City	or Town, State  WINGS MILLS
Baltimor	perrit. Page Department Important: If any injury or		21. Signatur of uneral Service Licensee	1			dress of Facility URBORAW FUI			MINGS MITTES
	205 g		23a. Pan1. Enter the disease, or complication	ns that caused i		91 WILLI	S ST. WEST	IMINSTER	2. MD 211	57 Approximate
	Physician		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	use on Jach line	DOX'.	espira	4 -	- (4,00	3	Interval Between On and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	,U,	1 0	i, lar	1_	my
- 1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	obstruc	time pull	nonco	i Seas	H MUNTU
	e be executed rsician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	end	-stage	renal	2 Nidean	most
68760,	icate be executed physician and s the burial-transit	dical E			multi	Ac m	relma			
			IF FEMALE: 23c If	yes, outcome o	f oregnancy					
. Box	atte	Physician/M	in the past 12 months?	☐Live birth 2 ☐Pregnant at t	Fetal death 3	□Ectopic pregnar □ Other (specify)		5	23d. Date of Month	delivery Day Year
P.O.	that the		9 ☐ Unknown 9  Part II. Other significant conditions contribut		not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
spic	w requires that the debeen signed by the should be detached	ted by								Probably Unknown
3ecc	ne law re has be ge 2 shi	Completed						24a. Was a autops perfor	sy pnor	autopsy findings available to completion of cause of
<u>ta</u>	ician: The certificate hare	a)	25. Was case referred to medical				26. Place of Death	1 Tes	200 101	es 2□ No
of <	Physician: this certific al director,	ToB	examiner? 1 Yes 25 No Hospit  27. Manner of leath 28	Inpatien		AII 3 DOA	Other: 4 🗆 Nursing Ho	me 5□Reside	ence 6 Other (S	pecify)
ion	ath. r: After re funer	ation	1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day	Year) 28b. Time Injury	. v	Vork?	28d. Describe h	ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory, offic	Се	28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
J	pspital hours a uneral (	al Ce	29a. Certifier Certifying Physician	: To the best of	my knowled a dea	th occurred at the	time, date and stana.	and dually their	ause(s) and manner	us stated.
	thin 24 thin 24 the Fu	Medical	(Check only 2   Medical Examiner: (	on the basis of e	examination and/or i	nvestigation, in m	y opinion, death occurr	ed at the time, d	late and place, and o	due to the cause(s)
				mD		-	5496		19d. Date signed (Mi	7 05
	AVITON		30. Name and address person who comple	ted cause of dea	ath (Item 23a) (Tyde	, Print) GRE	ST, BALTIM	ORE MEDIC	AL CENTER	1
e	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		3) 155111	THE IN	17616	+
6	Registr	ar	DEC 0 2 2005	Kee	w It	breeks				

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year NISKANEN DECEMBER 1, 1420PM M /Medical 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 216 SURREY CIRCLE DRIVE FT. WASHINGTON PRINCE GEORGE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2/XF Months Hours 578-24-3385 Yrs. Director 69 WASHINGTON, DC 06/13/1936 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location or than "natural, or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes ¾XNo PRINCE GEORGE FT. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 SURREY CIRCLE DRIVE 20744 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXo Completed by Specify 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH BOWIE BETSY TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY L. NISKANEN 12114 PAWNEE DRIVE, N. POTOMAC, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. MT. COMFORT CEMETERY \* 4 ☐ Donation 5 ☐ Other (Specify) 12/05/05 ALEXANDRIA, VIRGINIA 21. anation 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON ST ALEXANDRIA VA 22314 Dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease or coor shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to in reclaid cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of): by Physician/Medical use as IF FEMALE 23c. Il yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time ol death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day P.O. 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? YPERTENSION 1 Yes 2 No 3 Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide vithin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anthony C (orwell: MD 00023592 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. N. N. CONTRACTOR OF THE 31. Date liled (Month, Day, Year) State DEC 0 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗎 1 - State Registres Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 26, 2005 19:05 p M Frank Stevens Newsome, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown 24454 Lambs Meadow Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, June 21, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☑ M 2 ☐ F 80 219-20-8682 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at Worton 1 ☐ Yes 2 No MD Kent Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21678 USA 24454 Lambs Meadow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Ital any injury or other traumatic events. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret Spencer Walker Lewis Frances Newsome ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Spray Newsome/Wife 24454 Lambs Meadow Road, Worton, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Chester Cemetery Nov. 30, 2005 Chestertown, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Fellows, Helfenbein & Newnam
130 Speer ROad, CHestertown, 21. Signature of Funeral Service Licenses Funeral Home, P.A. MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIO PULLERAM /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) an/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death signed by the at d be detached for Physici 1 ☐ Yes 2 ☐ No 9 Unknown O 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy History of lymphones 1 Yes 2 No 25. Was case ref\_rred to medical / examiner?
1 ☐ Yes 2 ☑ No filled in by the tuneral director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury or Attending 1 Natural 5 Pendina after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To tha Funaral C

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 123889 11/29/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2(9)5 1676 Street, Chestertown, Wed 21620 Tu, W.D. ARRABAC John C. 32. Registar's Signature 31. Date filed (Month, Day, Year) State NOV 3 6 2005

Registrar

Please Type or Printin Black Indelible Ink Ensure All Copies Are Legible.

Amend item 23a per meo 8850 12 22 05 Vt

Amend Nama (Nama 235) 1 2 13 Vt

Amend Nama (Nama 235) 1 2 13 Vt For State Registrar 1-Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Stephanie Louise Nohe Month **Physician** ephanic NOHE 255 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Trauma Cenku balhmore If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min Days Hours 1 M & X 25 Yrs. Director 232-31-5331 AUG. 27, 1980 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a State 10b County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND CHARLES LA PLATA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 1400 REDWOOD CIRCLE U.S.A. 20646 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than COLLEGE of SOUTHERN 12 5+ NURSING STUDENT 18. Mother's Name (First, Middle, Maiden Sumame) MARYLAND 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Himportant: If Item 27 is marked oth any giving or other treumatic event page. Be STEPHEN M. NOHE 2 LINDA MARIE DRESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA TURNER - MOTHER 1400 REDWOOD CIRCLE, LA PLATA, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MET METROPOLI CREMATORY 12-14-05 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. PLATA MARYLAND 20646
iode of dying, such as cardiac of respiratory arrest,
Injuries 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Multiple Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Outil /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit HEMONHA that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 5 Other (specify) of Vital Records, P.O. 9 Unknown 3e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CERTIFICATION 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No репоглед? 1 ☐ Yes 2 No the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) After III:35 A M 5 Pending 1 Natural 1 ☐ Yes 2 No 07/05 within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation motor vehicle (ullisan 2 Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Grain Hwy & Fairhavan 3 Suicide 28e 4 Homicide Road

Ave, upper Maribero in

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Road 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) Center SNOCK 'a01a

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First Middle Last) Day Year Month **Physician** PARKER LOUISE Secember 2 2005 40 County of Death ANNA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Paninsula Regional Medical Centu NICOMICO SQIISBUIL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

OCT • 27, 1940 Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 257F 217-38-2553 65 GEORGIA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State traumatic avent, the Medical Examiner must be notified at 1 XYes 2 ☐ No SUSSEX BLADES Director DELAWARE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number itama 23a or 19973 AMERICA 300 EAST HIGH STREET Completed by Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Marned 1 Yes No Specify: Specify: WHITE 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHILD CARE DAY CARE PROVIDER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be filt Department of Heelth and Mental Hy Important: if itam 27 is marked oth any injury or other traumatic avent page. Be LOUISE MIXON LLOYD BROWN SKELICHE TONY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 300 E. HIGH STREET BLADES, DELAWARE 19973 DALE L. PARKER HUSBAND アカス トロ Baltimore 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Slate 20a. Method of Disposition ODD FELLOWS 1 Burial 2 Cremation 3 Removal from State 12/6/05 SEAFORD, DELAWARE 4 Donation 5 Other (Specify) CEMETERY 21. Signature of Fund WATSON-YATES FUNERAL HOME, INC. al Service Liden SEAFORD, DELAWARE 19973 mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory agests on each line. 28a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death ease, or complications e. List only one caus **Physician** resulting in death /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burlal-transit 0 that initiated events inding physicien and use as the burlat-tran resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy etter Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ā 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/OutpatienI 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injun 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident neral Diractor: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after To the Hospital within 24 hours a To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

3

Q.

MARALA

(arrol1

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 0 8 2005

31. Date filed (Month, Day, Year)

12/2/5

Salisbury MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 4146 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2112 DECEMBER 3 2005 Stella Ann Petrusik /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NICOMICO Canta Sallsbull Medical Teninsula If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🗓 F 126-18-3729 Yrs 84 March 16,1921 Pennsylvannia Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10b County 1X Yes 2 □ No Director Maryland Wicomico Hebron 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21830 209 West Church Street by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Efementary/Secondary (0-12) Garment Manufacturing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angeline Kryzawanos John Trotz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 243, Mardela Springs, MD 21837 Patricia Edwards/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Delmar, Delaware 12/5/2005 Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Down e Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary artery disease YRU15 Due to (or as a consequence of): Carolic my opathy Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner Right fracture, osteo porosis R. Lt L:

Due to (or a consequence of): that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 donknown Hypertension 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 27. Manney of Death 28c. Injury at Work? 1 (ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and slace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

sate has been signed by the a page 2 should be deteched of Vital Records, certificate has funeral director, After or Attending within 24 hours after death.

To the Funerei Director; A comoletely filled in by the ft Hospital

Examiner

**Funeral** 

Director

or items 23a or 28e-f show

is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itsm 27 is marked other then "natural", or itsms 23a or 28e-1 show other traumatic event, the Medical Examinar must be notified at

Department of Health a important: if itsm 27 is any injury or other tra

Physician

/Medical

Examiner

use as the

Pages 1

Maryland 21215-0036

Baltimore,

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State Registrar

Fernando Ade 31. Date filed (Month, Day, Year)

DEC 0 7 2005

29b. Signature and title of certifier

32. Registrar's Signature

Fernando J. ale, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll St. Salisbury MD 21801

29c. License number

D2041211

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Maryland		artment <i>rtificate</i>			Mental Hy	giene	5	41447
	Dhustai	*	1. Decedent's Name (First, Middle, Las	et)					2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medio			n Elwood Pegg					Decemb	er 11,	2005	10:05 <sub>Р м</sub>
1	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, 1	own, or L	ocation of Death	1	4c. Coun	y of Death	n
	2		46293 Pegg Lane					n Park	T	St. M		
	Funeral		5. Social Security Number 6. S	7. Age (In yrs. ia M 2□ F		If Under Months		Hours Min.	8. Date of Bi (Month, D	rth ay, Ye <i>ar</i> )	Col	nplace (State or Foreign
J.	Director		577-05-1743 Usual Residence of Decedent	3	2, 113.				October	17, 1913	Mar	yland
	land ow		10a. State 10b. County	10c. City	Town or Lo	cation						10d. Inside City Limits
	Mary	ţō	Maryland St. Mary	's Les	ingto	n Parl	<i>c</i>					1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number			10f. Zip				10g. Citizen of	What Co	untry?
	h with		46293 Pegg Lane			206	553			USA		
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decede	nt of Hisp	anic Origin? (S) Mexican, Puert	pecify Yes or N	o- 14. Ra		ncan Indian,
ဖွ	or It	E	1 Never Married 2 Married	1 ☐ Yes 2 X No		Yes 2	-	Specify:	o nican, etc.)		ack, White	
ဋ္ဌ	ours	d by	3 🕅 Widowed 4 □ Divorced	Year or Dates:		103 2	77 140	Specify.		Spec	Wh:	1te
بر آ	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	ient's Usual kind of worl	done dur	on ring most of wor	king	16b. Kind of I	Business/l	ndustry
12	within ne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	_	DO NOT use	retired)			W G G		
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Iteme 23a or 28a-f ehow ant, Ita Medical Examinar must be notified at		12 17. Father's Name (First, Middle, Last)		Carpe	nter	11	8. Mother's Nam	o (First Middle	U.S. Gove		t
anc	ntal h	Be		D							me)	
2	thoulk d Me mark matk	7	William Franklin 1  19a. Informant's Name/Relationship (7)		19h Mailir	n Address		rucy Gene d Number or Ru			State 7	in Code)
<u>⊠</u>	th an		Donald Elwood Strickla			<u> </u>						
ō,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel; or Iteme 23a or 28a-f show amy injury or other traumatic event, Ita Medical Examinat must be notified at Ance.		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Nam	e of	load, Grea	Date	20c. Location		
Baltimore,	ages ant of it: if I		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State	metery, cren	-		!	ember			
量	artme ortan injur		21. Signature of Funeral Service Licen	Gildi	les Mem				2005	Leonard	lown,	Maryland
Ba	Depa Impo eny ii		michael Yeeri	Hord J				of Facility diner Fun Leonardto				
• 45			23a, Part1, Enter the disease, or comp	olications that caused the death.								Approximate
	Physician		shock, or heart failure. List only a Immediate Cause (Final	one cause on each line.	1		14	21/11	0			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Ou ( > 1	ance of):	420	11	20 000	<u> </u>			6 monty
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မ	ing pt	Med	IF FEMALE:						_			
Box	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal		Ectopic pre	gnancy				ate of deli-	very Day Year
<u>.</u>	the a	sic	1 Yes 2 No	4☐ Pregnant at time of dea	ath 5⊡	Other (spe	cify)			TVI	Ortin	Day Feat
Division of Vital Records, P.O.	that the death certific ed by the attending p detached for use as	by Physician/Me	Part II. Other significant conditions of	patributing to dooth but not recul	ting in the	adashian an		in Dark I	220 Did			the cause of death?
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Sec.	e law has t	Completed							24a. Was	psy	prior to o	opsy findings available ompletion of cause of
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<u> </u>	Attending Physician: The lar r death. ector: Alter this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Dea				
ot	Phys r this ral di	7.	1 Yes 2 No 27 Manner of Death	1 Inpatient 2 E	R/Outpatien 28b. Time of		`	4   Nursing n		dence 6 Ot how injury occu	her (Spec	ify)
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S	deat ctor: y the	flca	3 ☐ Suicide 6 ☐ Could not be	1	ne, farm, stre				28f. Location (	Street and Num	ber or Rui	ral Route Number.
<u> </u>	after after Dire	Certification:	4 Homicide determined	building, etc. (Specify)		. ,.			City or To	wn, State)		
	To the Hospital or Attending in within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	rledge, death	occurred a	t the time,	date and place,	and due to the	cause(s) and m	anner as	stated.
	n 24 no Fu	Medical	(Check only 2 Medical Examone)	iner: On the basis of examination and manner stated.	on and/or inv	estigation,	n my opin	ion, death occur	red at the time,	date and place	and due	to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier		. \	29c.	License n	_		29d. Date sign	ed (Month	Day, Year)
)	m		1 hour W	ente	m)	(	100	0504	-	(2)	121	05
10	N		30. Name and address of person who o	completed cause of death (Item	23а) (Туре,	Print)						
_			Leon W. Berube, M.D.	28170 Old Village		Mechani	csvil	le, Maryl	and 20659			
	Sta	31	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	-							
44	Registr	ar	DEC 1 2 200	5	local	43						

Elizabeth Ouade

Name: Mary

			1- State Registrar Amended it  1. Decedent's Name (First, Middle, La	em #4c pe	Maryland / Depa r fh/wickd9			-7-05/d1s Re	g. No. U U	5 41449
п	Physic	ian	1. Decedent's Name (Pirst, Middle, La	st)				2. Date of Death Month		Year 3. Time of Death
	/Medi Exami		Leonard Ray 4a. Facility Name (If not institution, giv		r)	4b. City, Town, o	r Location of De	Dec.	4c. County o	2005 1550 PM
			Snow Hill Nursin			Snow			Wic	cester
B	Funeral Director		5. Social Security Number 6. S	Sex 7. A	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birth (Month, Day, Jul. 2,	Year) 1923	Birthplace (State or Foreign Country)     Tennessee
	pu		Usual Residence of Decedent  10a. State 10b. County		100 Cit. T					
	sho	7	Tod. State		10c. City, Town or Lo	cation				10d. Inside City Limits
	he M	Director	DE Suss	ex	Lewes					1 DXYes 2 □ No
	with t	급	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Country?
	eath	era	3 Harborview Ro	ad 12. Was Deceder	t Sverin II C and		19958	(0)		S.A.
36	be filed within 72 hours after death with the Maryland that Hyglene.  Very deather then "neturel", or Items 23a or 28e-1 show event. I'm Medical Evariner must be netified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 \ Yes 2 \ If Yes, Give	? ] No	Vas Decedent of H fYes, specify Cuba I□Yes ŻŒNo	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, White, etc.
8	hour ture	pe pe	15. Decedent's E	Year or Dates	: 1940-1949					White
21215-0036	within 72 ene. then ne	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of w	vorking	6b. Kind of Bus	iness/Industry
7	filed with Hygiene ither the	So		2	Mas	er Sarge	ant		U.S. 1	\rmv_
Maryland	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last,			- 10	18. Mother's N	lame (First, Middle, Ma	aiden Sumame,	)
<u>Y</u> a	should be ind Mental I	70	Willard Parker					e Lancaste		
Jar	0 0 0		19a. Informant's Name/Relationship (		19b. Mailin	g Address (Street	and Number or	Rural Route Number, (	City or Town, S	tate, Zip Code)
	1 and 2 Health tem 27		Margit S. Riley	/ Spouse	3 Ha	arborview	Road,		19958	<u></u>
altimore,	0 0		20a. Method of Disposition 1 X Kurial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispos	sition (Name of natory or other plac	e)	Date 20	Oc. Location - C	ity or Town, State
Ē	Ра tent:		*4 □ Donation 5 □ Other (Specif	y)	DE Veterans	Mem. Ceme	terv Dec	8, 2005	Millstor	r. IE
Ba	permit. Pag Department Importent: I any injury o		21. Signature of Timeral Service Licer	aisable	7 Pa	Name and Address arsell Fu	ss of Facility Ineral H	Homes & Cre	ematoriu	am
	3F-		23a. Part1. Enter the disease, or comshock, or hear failure. List only	plications that cause	ed the death. Do not ente	6961 Kin or the mode of dyin	gs High	way, Lewes	y DE 1	9958 <sub>Approximate</sub>
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence of):	rtery	Disea	10		Interval Between Onset and Death
68/60,	ficate be executed in physician and sthe burial-transit	edical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of): s a consequence of):					
P.O. Box 6	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
	pe jo	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the un	derlying cause give	en in Part I.			ute to the cause of death?
010	requ	ted						1 Tes	2 □ No 3	Probably 4 Whiknown
ř	The law ate has b page 2 s	Completed						24a. Was an autopsy performe	d? prid	re autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
7112	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	t to activate				eath (Check only one)		
	<b>%</b> ≥ □	မ	1 Yes 2 No	Hospital: 1 ☐ Inpat		3□ DOA Othe	4 Librursing	Home 5 Residence		
noi	Attending F r death. ector: After by the funera	atlon	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Inj (Month, D	ury 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? ′es 2 □ No	28d. Describe how	injury occurred	
_	Dir the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	iury - At home, farm, stre tc. <i>(Specify)</i>	et, factory, office		28f. Location (Stree City or Town, S	et and Number ( State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel C completely filled i	edical	29a. Certifier (Check only one)	ysician: To the best liner: On the basis and manner s	of my knowledge, death of examination and/or inve lated.	occurred at the timestigation, in my op	e, date and place inion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner and place, and	er as stated. I due to the cause(s)
	Vithi Vithi Comp	M	29b. Signature and title of certifier	)errol, 1	uD	29c. License		29d.	Date signed (A	Month, Day, Year)
	11/83		30. Name and address of person who of SARAD R. BA	completed cause of RAL, M	death (Item 23a) (Type, P	rint) Mars &	e + 5	+ Para	ma L	3.2005 M) 2185/
<b>1</b>	Sta Registr	_	31. Date filed (Month, Day Year) DEC 0 8 2		rar's Signature	2		/ / 0 00	100	, My 2105/

			State of Maryland / Department of Hea  1- State Registrer  Certificate of Dec			ene g. No. 2 0 0 5	6 41450
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Richard Dale Rupert		Dec.	3 2005	
1	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local			4c. County of Dea	
			7440 Dance Hall Road Frederic			Frede	
	Funeral Director		205–16–7712 1 M 2 F 80 Yrs. Months Days He	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 30	, 1925 1	rthplace (State or Foreign country) PA
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryli I eho	5	MD Frederick Frederick				1 ☐ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What C	country?
	death with the Maryland ms 23s or 28s-f ehow trives be notified at	<u>=</u>		21701		United	States
	ne 2%	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispar	anic Origin? (Sp	pecify Yes or No-	14. Race - Am	
0	r iter	Fur	1 Never Married 2 Married 1 M Yes 2 No 1943	viexican, Puenc Specify:	rican, etc.)	Black, Wh	white
3	hours after turel', or ite	ð	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946	эрөспу.			
9500-612		Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done durin	n ing most of work	king	16b. Kind of Busines:	s/Industry
7	within 72 ene. then nei	npi	Elementary/Secondary (0-12) College (1-4or 5+)			an 1 f	-employed
2	filed w Hygier sthar ti	ខ	17. Father's Name (First, Middle, Last)  18.	Mother's Nam	ne (First, Middle, N		-eliptoyed
Maryland	S d a D	Be				nche Boohe	ar.
Ž	should and Men marke umatic	ဥ	Kenneth Edgar Rupert  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and It				
Z Z	t a t		T110 T T1				21701
	s 1 and f Health Item 27 other to	13	20a Method of Disposition 20b. Place of Disposition (Name of			20c. Location - City of	
٥	9°= 5		1 □ Burial 2 ☆ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  South Carroll Crema	atory D	ec. 4. 2	005 Winf	ield, MD
Baltimore,	mit. Pag bertment bortant: Injury :		21. Signature of Trial Service Licensee  22. Name and Address of Burrier-Quee				
B	permit. Depertrimports any Inj.		Burrier-Quee	en rune: Tibert	rai Home v Road V	& Cremato Vinfield.	MD 21784
			23a. Fart1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, su should or heart failure. List only one cause on each line.	such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Ir media & Cause (Final pisease or condition a Respitory avvest				Onset and Death
1	/Medical		If media a Cause (Final disease / r condition resulting in death)  a. Respitor avvest  Due to (or as a consequence of):				
п	Examiner		Sequentially list conditions, b. Ischemic Cardway	10 Pethy	1		
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Covondo Arte Covondo Arte Covondo Arte Covondo Covondo Arte Covondo Covondo Arte Covondo Covondo Covondo Arte Covondo Cov		1.	-006	
	te be executed ysicien and ie burial-transit	Examiner	that initiated events	D13600	e sp	CHBG	
760,	e exe ien al		resulting in death) Last Due to (or as a consequence of):	2.0	, Link	-1.2	
	9 % 9	Ilcai	CVA ICD Vent	nauco	1000	Crank	
68 68	Attending Physicien: The law requires that the death certificate r death. •ctor: Atler this certificate has been signed by the ettending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE:				- Constant
P.O. Box	ath co	jan	23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of d Month	elivery Day Year
_ O	uires that the der signed by the e Id be detached f	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)				
	that the	4	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	sign d be				1 □ Ye	s 2 □ No 3 □ I	Probably 4 Unknown
Ö	w require been sign	Completed			24a. Was a	n 24b. Were	autopsy findings available
ĕ	has has	윹			autops perform	v prior to	completion of cause of
<u>_</u>	n: The ficete or. pa		25. Was case referred to medical 26	E Place of Dea	1 ☐ Yes 2 th (Check only on		as 2□ No
⋚	sicie : certi	o Be				nce 6 ⊡Other (Sp	pecify)
ō	Phy or this oral d	5	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			w injury occurred	
0	th. : Afte	ş	1 XNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes	s 2□No			
Division of Vital Records,	Atter r dea ector by th	100	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	1325	28f. Location (St. City or Town	reet and Number or i	Rural Route Number,
Ó	s efter of Directory	Certification:	During, etc. (Specify)				
	To the Hospital or Attending Physicien: The I within 24 hours efter death.  To the Funarel Director: After this certificate hat completely filled in by the funeral director, page	Medicai	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, of the companion of the com				
	To th Within To th	Me	29b. Signature and title of certifier 29c. License nu	umber	2	9d. Date signed (Mo	
		ID	1 14hah - 000	5710	T	12 03 8	1005
	MJ	1/4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Thomas	s John	son Drive	# 202
	10x1		NIRMAL K SHAH, MD, FACC Fre	denc	k, m	10 217	2 # 202
		ate	31. Date filed (Month, Day, Year)  DEC 0 5 2005  Source St. Apartic				
	Regist	_	DEC O D 2007 Stoken St. Sparke		_		
DH	IMH 17 Rev 1/2	2001					

DHMH 17 Rev 1/2001

OK per DIANA BARBOUR

		1	For State Registrar	State of Ma	ryland /	-	artment of H		Mental Hy	/giene	0.05	41451
			Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death
	sicia		Margaret Hershber	ger Ross					Decem	Day	Year	5 1505PM
	edica mine		la. Facility Name (If not institution, give st				4b. City, Town, or	Location of Deat			County of Deal	th
			Washington Count	y Hospita	ıl		Hag	erstown		1	Washing	ton
Fune	ral		5. Social Security Number 6. Sex	X	(In yrs. last i		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B	irth av. Year)	9. Bin	hplace (State or Foreign nuntry)
Direc	tor		213-18-9352	M 2Å F 9	1	Yrs.			Nov.6,	1914		ryland
pug *	a'i	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
danyia I sho		. 1	Md. Washing		•		ithsburg					1 XYes 2 No
the N		ect	10e. Street and Number	-	-	SIII.	10f. Zip Code			10a. Citi	izen of What Co	ountry?
with	2	Funeral Director	43 E. Water St. P.	O. Box 3				.783			U.S	-
death ms 2:		era	11. Marital Status	2. Was Decedent Ev	ver in U.S.	13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or N	0-	14. Race - Ame	nican Indian,
is 5, INIAL 9 IALITY A LATE 1970000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show	a iii	by Fur	1 Never Married 2 Married  **Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			r Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	o Hican, etc.)		Black, Whit	e, etc. White
2 ho		ted	15. Decedent's Educ (Specify only highest grade		16	Sa. Dece	dent's Usual Occup	ation	rkina	16b. Ki	ind of Business	Industry
thin 7		Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	_	kind of work done on DO NOT use retired	dining most of wo	iking			
ed wi	9	S	8			P	Manager			1	ool Cafe	eteria
tai H		Be	17. Father's Name (First, Middle, Last)					18. Mother's Na				
2 shoutd and Men is marke	200	ဍ	Louis S. Hershberg						die A.			
VICE I			19a. Informant's Name/Relationship (Type Bryan J. Ross (Gra				ng Address <i>(Street :</i> 5. <b>Georgi</b>					•
T and lealth	191	-	20a. Method of Disposition	nuson/			sition (Name of	a Ave. M	Date		ocation - City or	
permit. Pages Department of t importent: # ite	5		1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	ceme	tery, crer	natory or other plac	Dec.				
mit. Pages partment of portent: If it	dan's	-	`4 □Donation 5 □Other (Specify)		Smith		cg Cemete  Name and Addres	- 20	05		ithsburg	
Demit. Departr Importe	once.		21. Signature of Funeral Service License									iry Ave.
			23a. Part1. Enter the disease, or complic				L. Davis				isburg,	Approximate
			shock, or heart failure. List only one	cause on each line	).	i	Α	00				Interval Between Onset and Death
Physic /Medi			disease or condition resulting in death)	Nes	pin	Hor	5 70	iller	<u>e</u>			
Exami				Due to (or as a	consequend	(a)	10 9	0 0 1 0				
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	consequence	e of):	parce	acc				
V pen p	a list	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Se	B 61.	18	V					
cate be executed physician and	<u>a</u> -	Exa	resulting in death) Last	Due to (or as a	consequence	e of):	1		0 0			
te be ysicik	0 0	dical	d.	Cor	1 Cls	hill	e he	out	Fail	un		
The law requires that the death certificate be executed ate has been signed by the attending physician and	20	Ved	IF FEMALE:		0				0			
w requires that the death certifications is gined by the attending process.	nse l	Physician/Me	23b. Was decedent pregnant	<li>c. If yes, outcome of 1 ☐ Live birth 2</li>		ıth 3□	Ectopic pregnancy			1	23d. Date of del Month	ivery Day Year
e dea	0	sici	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at ti 9□Unknown	ime of death	5 [	Other (specify)				MOHUI	Day 16a1
nat the	eraci	Phy	9 Unknown	abuting to dooth but	not roculting	a in the u	a dark ing agusa ga	on in Bort I	22a Did	tobacco	no contributo to	the cause of death?
res th	9	þ	Part II. Other significant conditions cont	. 10	not resulting	IN (NO UI	nderlying cause give	on in rait i.		Yes 2		./
w requires to been signed	ono.	ted	and any a	ing	GUS	eu,	ic, a	siann	1			
a law	7	ompieted	1						24a. Wa	s an opsy ormed2	24b. Were at prior to death?	itopsy findings available completion of cause of
The	<u> </u>	S							1 ☐ Yes	2 No		2□ No
rsicien: The law	director,	Be	25. Was case referred to medical examiner?	ospital:			Oth	26. Place of Dea				
Phys C	<u> </u>	To	1 Yes 2 No	28a. Date of Injury		Outpatien  Time of	IL 3L DOA	4   Nursing F	lome 5 Res			cify)
ding Phys	tne runeral	tion	1 Natural 5 Pending	(Month, Day	Year)	Injury	Wor	k?` Yes 2∐No	200. 50001150	now injur	y cocanoc	
Attending Physicien: or death.	y tue	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home.	farm, str			28f. Location	(Street an	d Number or Ri	ıral Route Number,
for A Dire		ertii	4 Homicide determined	building, etc.	(Specify)		,,		City or To	wn, State	)	
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A		caic	29a. Certifier 1 Certifying Physic (Check only 2 Medical Exemin									
the H in 24 the F	pieid	ledicai	one)	and manner state	ed.							
S A S	COL	Σ	29b. Signature and title of certifier				29c. License		,	29d. Dat	e signed (Mont.	/
Ĭ.			1 m sao		S			2585		12	116	12005
1	1		30. Name and address of person who cor	npleted cause of de	ath (Item 23a	a) (Type,	Print)	T HALL	ENSTOW	7/1	70 9	1740
			31. Date filed (Month, Day, Year)	32. Registrar		/ (1% )	COLITAIN	/	-, -, -	1	-0 2	
Re	Stai gistra			3/		10	1.0.					
DHMH 17 Re			DEC 2-2-2	005	as L	1	0300					
				No.	OF	IGINA	\L					

/id	Ross		For Amend Items	State of Maryland 21,28a-fper F	H/HE CBS	on 2/22/0 ate of Deat	and Mei <b>5dhb</b> <i>h</i>		iepe	JO	+1452
	Physici	an	1. Decedent's Name (First, Middle, Last,	Ross			L	Date of Deat Month	Day	Year 2005	3. Time of Death
X	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Locatio	n of Death	ovember	4c. Cour	nty of Death	10:33 A
	Funeral	Sept.	1236 Dockside Dri				er 24 Hrs. 8.	Date of Birth (Monkh, Day)		9. Birthp	place (State or Foreign
e <sup>2</sup>	Director		211-40-4245 1) Usual Residence of Decedent	(M 20F 55	Yrs. Mont	ns Days Hours	Min.	(Morkh, Day,	950	Lan	caster, HA
	Aaryland f show	or	10a. State 10b. County	1	Town or Location	Two				1	0d. Inside City Limits
	deeth with the Maryland ms 23a or 28a-f show r must be παιιίτεσ st	i Director	10e. Street and Number	erville Ro		Zip Code	3	1	0g. Citizen d	of What Cour	itry?
5-0036	s after , or its	d by Funerai	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1 ☐ Ye	/			Spec	. 00	etc.
15-0	in 72 hours "natural" legical Ex	oletec	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decedent's U (Give kind of life. DO NO	Isual Occupation work done during m Tuse retired)	ost of working		<u> </u>	Business/Ind	dustry
2121	filed with Hygiene. sther than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	esti	mator	ther's Name (F	Time Adjuster A	Cons		Tion
Maryland	b d its	To Be	17. Father's Name (First, Middle, Last)	ROSS			Olivi	a E	ate	hell	/
	d 2 s th ar th ar trau		19a. Informant's Name/Relationship (T)	rpe, Print) KUSS	759 Br	ess (Street and Num	le Ko	1,Lit	tz, F	14/1	543
Baltimore,	Pages 1 en ment of Heal ent: If item 2 lury or other		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	netery, crematory	Name of or other place)	11/251	105	20c. Lócatio Cola	in - City or To	7540
Balti	permit. Departm Importe sny inju		21. Signature of Funeral Service Licens	Thomas S. B	uter 22. Name	and Address of Page 7 5 Br	cility Spa	Sto	tit	ZAF	17543
	Physician /Medical		23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line.  Due to (or as a consequence)	le I	node of dying, such	as cardiac or ri	espiratory arre	est,		Approximate Interval Between Onset and Death
,00	ificate be executed executed g physicien and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
O. Box 68760,	ne death certificate b the ettending physic hed for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	death 3□Ectop	c pregnancy (specify)				Date of delive	ery Day Year
ls, P.O.	res that the signed by be detact	by Phy	Part II. Dther significent conditions co	ntributing to death but not resul	ting in the underlyi	ng cause given in Pa	rt I.	23e. Did tob	1		he cause of death?
Division of Vital Records,	The law requires that the death cert tte hes been signed by the ettending page 2 should be detached for use a	Completed						24a. Was a autops perform Yes	n 24 y ned?	b. Were auto prior to co death?	opsy findings available impletion of cause of
Vita	ician: certifica rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	TD:0		ace of Death (C			24	<sup>(y)</sup> Scene
of of	ig Physiter this neral di	on: To	1 ☐XYes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending		28b. Tir <b>Found</b>	28c. Injury at Work?		d. Describe ho			" Scene
Division	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Certification:	1   Natural 2   Pending investigation   1   Suicide 4   Homicide   Homicide   Suicide   11/19/2005 28e. Place of Injury - At hor building, etc. (Specify) constructio		1 ☐ Yes 2g	281	City or Town	reet and Nu n, State)		al Route Number, Balto., MD	
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical C		vsician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death occur		and place, and	d due to the ca	ause(s) and	manner as s	stated.
	To the To the comple	Me	29b. Signature and title of certifier	1 01		29c. License numbe	ər	1	-	ned (Month, per 20	
	17		30. Name and address of person tho o								,
399 16		ate	31. Date liled (Month, Day, Year)	7(N.). 111 Penn 32. Registrar's Signati	ure	altimore N	ary1an	a 2120.	L		
DE	Regist	- 14	DEC 2 2 2005	Bear & A	208464						

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and Mertificate of Death	ental Hygien Reg. N	11100				
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death				
	Physici: /Medic		Annie J. Smith			29 2005 10:15 P <sup>M</sup>				
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	lc. County of Death				
			Prince George's Hospital	Cheverly		Prince George's				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)				
	Director		240-60-5694		Sep. 11,	1917 North Carolina				
	w w	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits				
	Aaryli f sho	ō	V 1 1 D 1 0	0 1 1 7 1 1 .		1∭XYes 2 ☐ No				
	28a-	Director	Maryland Prince George's	Capitol Heights 10f. Zip Code		Citizen of What Country?				
	with Se or		517 Clovis Ave.	20743		United States				
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Indian,				
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Exclusion must be notified at an once.	Funeral	Armed Forces?  1 Never Married 2 X Married   Armed Forces?  1 Yes 2 X No   If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Specify: Black				
21215-0036	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	-	105	l				
<del>1</del> 5	"nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 166.	Kind of Business/Industry				
7	with ene.	mc	Elementary/Secondary (0-12) College (1-4or 5+)	Housewife		Private				
9	filled Hygi other	o l	17. Father's Name (First, Middle, Last)		(First, Middle, Maide					
Maryland	Ald be fental rked c	To B	Walter Jordan		Mannie 1	Boddie				
ary	shou and N s ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura	l Route Number, City	or Town, State, Zip Code)				
	ss 1 and 2 of Health of Item 27 i			Clovis Ave., Capi						
Baltimore,	Jes 1 r of H if Item		20a. Method of Disposition  20b. Place of Disposition  1 Burial 2 Cremation 3 Removal from State	osition (Name of amatory or other plates rk	ate 20c.	Location - City or Town, State				
Ë	tent:			l National Mem. 12/		Laure1, MD				
Bal	permil Depar Impor any ir		21. Signature of Fruneral Service Licens-e		ewart Fund	eral Home .E. Wash., DC 20019				
	· ·		23a. Part / Enter the disease, or complications that caused the death. Do not en			Approximate				
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	· Car Pied Delayer	Tial	Interval Between Onset and Death				
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of)	ocardial inforces	204					
ı	Examiner		Sequentially list conditions, b. Coronary	artery discase						
	יים יים	iner	if any, leading to immediate  Due to (or as a consequence of):							
	and and I-trans	Examiner	Cause (Disease or injury that initiated events c							
8760,	cate be executed physician and the burial-transit									
687		edical	d							
Вох	death certifi e attending p id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery				
	0 0	Physician/Me	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year				
P.0	that the de led by the a detached f	hys	9 ☐ Unknown							
ŝ	Se Dec.	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?				
ord	w require been si should I	ted			1 Tes	2 No 3 Probably 4 ∃Unknown				
Record	law as b	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
=		Con			performed?					
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)					
of \	Physicien: this certific al director,	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			6 ☐ Other (Specify)				
on c	ling I. After fune	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 1 ☑Natural 5 ☐ Pending (Month, Day Year)	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred				
isi	or Attending uter death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Street)	and Number or Rural Route Number,				
Division	of or Attency after death Director:	Certification:	4 Homicide determined determined building, etc. (Specify)	rest, factory, office	City or Town, Ste	ite)				
	urs urs illec	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 Medicel Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a	and due to the cause	(s) and manner as stated.				
	To the Hosp within 24 ho To the Fund completely f	Medi	one) and manner stated.	29c. License number		Date signed (Month, Day, Year)				
	To To		29b. Signature and title of certifier	J 00 60339	250.0	2/12/2006				
	F		30. Name and address of person who completed cause of death (Item 23a) (Type		(	107-003				
K	- (3)		1. 101.0	al Drive, Cheverly	MD 2078	85				
	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature	W a						
	Regist	rar	DEC 0 7 2005							

				ortment of Health and M tificate of Death	lental Hygie							
į	Physici /Medio		Decedent's Name (First, Middle, Last)     CALLAS MAE SHARPE		2. Date of Death Month 12/04/0	Day Year 7:31 PM M						
	Examir		4a. Facility Name (If not institution, give street and number) 12720 LODE STREET	4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGE S						
	Funeral Director		5. Social Security Number 579-34-5998  6. Sex 1 M F 7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 09/07/1	9. Birthplace (State or Foreign Country) NORTH CAROLINA						
	Maryland ••f ehow	tor	10a. State 10b. County 10c. City, Town or Loc MD PRINCE GEORGE'S BOWIE	cation		10d. Inside City Limits 11∑Yes 2 □ No						
	th with the 23s or 28s	al Director	10e. Street and Number 12720 LODE STREET	10f. Zip Code 20720		Citizen of What Country?						
036	be filed within 72 hours after death with the Maryland stat hygiene.  Id thygiene.  Id other then "neturel", or items 23e or 28e-f ehow event. If a Maryla Exemiter is use the medical exemiter is used.	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK						
1215-0	within 72 ho ene. then "netur re Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  3 rd  16a. Decede (Give kite. D  WAITR	ent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing	v. Kind of Business/Industry						
/Jand 2	be d o	To Be Co	17. Father's Name (First, Middle, Last) TALLIE HARTSFIELD		(First, Middle, Mai							
Baltimore, Maryland 21215-0036	1 and 2 s Health ar tem 27 is		BETTY SPRUELL/DAUGHTER 12720  20a. Method of Disposition 20b. Place of Dispos	g Address (Street and Number or Rura LODE STREET BOWI) inition (Name of atory or other place)	E, MD 207							
Baltimo	permit. Pages Department of I Important: If it eny injury or o		*4 □ Donation 5 □ Other (Specify) ARLINGTON  21. Signature of Funeral Service Licensee 22.	NATIONAL CEM. 12, Name and Address of Facility MAR. O8 SUITLAND RD. SI	SHALL'S F							
	Prrysician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter show, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. END STAGE ALZHETME Due to (or as a consequence of):	or the mode of dying, such as cardiac o								
8/60,	cate be executed physician and the burial-transit	dical Examiner	d									
O. Box 6	death certifi e attending j id for use as	hysician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year						
cords, P	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		co use contribute to the cause of death?						
Ŭ L	The lay ate has page 2	Completed			24a. Was an autopsy performed							
on or vital	iding Physicien: Th th. After this certificate funeral director, pag	lon: To Be	25. Was case referred to medical examiner?  1 ☐ Yes XX No  27. Manner of Death XX Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	28c. Injury at Work?		e 6 □Other ( <i>Specify</i> ) njury occurred						
DIVISION	To the Hospitel or Attending P a within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Sertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	M 1 Tyes 2 No et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)						
	the Hospit in 24 houn he Funere pletely fille	edical C	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Exeminer: On the basis of examination and/or investance and manner stated.	occurred at the time, date and place, a sstigation, in my opinion, death occurred	and due to the cause and at the time, date	e(s) and manner as stated. and place, and due to the cause(s)						
	3	Σ	29b. Signature and title of certifler of Dorley MO	29c. License number D0021954		Date signed <i>(Month, Day, Year)</i> CEMBER 07, 2005						
	Bj		30. Name and address of person who completed cause of death (Item 23a) (Type, P EDWARD MOSLEY, M.D. 1011 WOODLA	,	MD							
	Sta Registr		31. Date filed (Month, Day, Year) DEC, 0 8 2005 32Registrar's Symature									

			For Stata Registrar	State o	f Marylar	•	irtment of H			giene 0 0	15	41455		
ı			Decedent's Name (First, Middle, Landson L	ast)					2. Date of De Month		Year	3. Time of Death		
	Physicia /Medic		MARGUI	RIETA J	ONES S	SIMMS			DECEMB		005	7:20 P. M		
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or Clint		ith	4c. County of Death  Prince Georges				
_			Southern Marylan  5. Social Security Number 6.	Sex NOSPI	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bir	th ly, Year 1946	9. Birtho	lace (State or Foreign		
	Funeral Director			1□M 2 <b>∏</b> F	59	Yrs.	Months Days	Hours Mir	rebrua	iry 4,	Cour	ginia		
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 0	ity. Town or Lo	cation				1	0d. Inside City Limits		
	ehov	ŏ		Coore		•	estville					1X Yes 2 □ No		
	28a-f	Director	Maryland Prine  10e. Street and Number	ce Georg	ges	FUL	10f. Zip Code			10g. Citizen of W	/hat Cour	ntry?		
	death with the Maryland me 23a or 28a-f ehow r.must be notified at	0	5205 Stoney Mea	adows Dr	ive		2074	7		United	Stat	es		
0000	be filed within 72 hours after death with the Marylan Ital Hygiene. In the "naturel", or Iteme 23a or 28a-f show or other than "naturel", or Iteme 23a or 28a-f show event, the Medical Evarrings must be notified at	by Funerai	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Dec Amed Fo 1  Yes If Yes, Gi Year or D	2 <b>X</b> No ve	i	Vas Decedent of H Yes, specify Cuba □ Yes 2 <b>X</b> No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	14. Race Blace Specify	k, White,	ean Indian, etc. .ack		
Ş	2 hou		15. Decedent's E (Specify only highest gi	ducation		16a. Deced	ent's Usual Occup	ation	orkina	16b. Kind of Bu	siness/In	dustry		
N	ithin 7	Completed	Elementary/Secondary (0-12)	Cottege (			kind of work done o		J. Mily	Povde (	llath	ing Store		
Z	Hygier Hygier other th		8th grade  17. Father's Name (First, Middle, Las	e1		S	ales Cle		ame (First, Middle			iting Store		
and	d be filed antal Hygi (ed other c event, 1	Be c	Moses Jones	.,				Maria		_	-/			
2	s 1 end 2 should be f if Health and Mental is item 27 is marked of other traumatic eve	ဥ	19a. Informant's Name/Retationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code) 20747		
Z,	l end 2 fealth a im 27 le her trau		Oliver Joseph S	imms (Hu	ısband)	5205	Stoney M	eadows D	rive;For	estville	, Ma	ryland		
e e	of He of He fitem r oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from		Place of Dispo- cemetery, cren	sition (Name of natory or other place	Dec	.12,2005	20c. Location -	City or To	own, State		
altimo	Peg Iment tent: I		4 □Donation 5 □ Other (Spec	ify)	Fo		coln Ceme					Maryland		
מש	permit. Peges Department of t Importent: If Ite any Injury or of		21. Signature of Funeral Safo Collection	ensae 2	1100	R 6	Name and Addre N. Hori 00 Kenne	ss of Facility ton Comp dy Stree	any Mort	icians, ashingto	Inc. n,D.	c. 20011		
ı			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	mplications that	caused the dea each line.	th. Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	$_{a.}$ $\rho_{n_{i}}$	umoniu							0.1301 4.13 50411		
	/Medical Examiner		resulting in death)	Due to	(or as a conse		+ 0-11	A.						
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse	quence of):	+ Styphylo	cole, and	reng		+	-		
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
5	e exec ien an urial-tr	Exa	resulting in death) Last	Due to	(or as a conse	quence of):								
8/00	cate be executed physicien and the burial-transit	dicat		d										
C. Box o	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 DM0 9   Unknown	1 ☐ Live	itcome of pregn birth 2 Fet nant at time of	aldeath 3	Ectopic pregnancy	,		23d. Dat Mor	e of delive	ery Day Year		
7.	requires that the de wen signed by the e hould be detached t	by Ph	Part II. Dther significant conditions	contributing to c	leath but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	tobacco use contr	ibute to th	ne cause of death?		
cords,	w requires been sign should be	ed b	Multiple Scleno	יאו					10	Yes 2 No	3 Prob	ably 4 Unknown		
Ē	The law ete hes b page 2 s	Completed							24a. Was auto perfo 1 🗆 Yes	psy prmed? p	Vere auto prior to co leath? Yes	psy findings available mpletion of cause of		
Z Z	Physiclan: r this certific ral director,	Be	25. Was case referred to medicat examiner?	Hospital:			Oth	or	eath (Check only					
	Physic this c	 T	1 Yes 2 No 27. Manner of Death	Ne.		ER/Outpatien	1 3 100	4 🗆 Nulsing	Home 5 ☐ Resi	how injury occurr		(y)		
0	dlng th. After fune	tlon	1 Natural 5 Pending 2 Accident investigati		of Injury oth, Day Year)	Injury	Wor	k? Yes 2 □ No		,,				
DIVISION OF	or Attending efter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not determine	4   288. Flac	e of Injury - At I ling, etc. (Spec	home, farm, str	eet, factory, office			Street and Number	er or Rura	al Route Number,		
_	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai Co	29a. Certifier Check only one) Certifying F	eminer: On the b	e best of my kn casis of examin	nowledge, death nation and/or in-	n occurred at the tir restigation, in my o	ne, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as s	tated. o the cause(s)		
	To the Within To the	Me	29b. Signature and tyle of certifier				29c. Licens			29d. Date signed	d (Month,	Day, Year)		
			· Waln		ms		D005	55120		Dec 5	2005	-		
1	(0)		30. Name and address of person whe Richard Palmer	-	se of death (Ite	em 23a) (Type, frem G	Print) Vehust Ju	1/k 310	washing	un DC	2003	2		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 8 20	05	Registrar's Sign	nature	2,							
						100								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:35 р. м **Physician** December 2, 2005 KERRY JON SEVERN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Hours Min. Washington, DC 1943 61 578-58-3121 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County orient: if item 27 is markad other than "natural", or items 23a or 28a-1 show injury or other treumatic event, the Medical Exercit er must be notified at 1 Yes 2 No Directo Prince George's College Park Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20740 6103 Seminole Street U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 1961 − Year or Dates: 1964 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Inventory Clerk and Mental Hygin 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lois Virginia Leftwich John Francis Severn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Importent: If item 27 is any injury or other treu E. Dianne Severn - Wife 6103 Seminole Street, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 12/8/2005 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 Moule Pant ff 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myses have Physician /Medical Due to (or as a consequence of): **Examiner** Considery Primary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Non Insulin Dependent Diabetes Mellitus; Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemias; Hypertension 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification; To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 X ER/Outpatient 3 DOA 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D16410 December 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Hanover Parkway, #105, Greenbelt, MD 20770 Gabriel Benjamin Jaffe, MD 31. Date filed (Month, Day, Year) . Registrar's Signature State DEC 0 8 2005 Registrar

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Ma	ryland			t of Heal			Reg. No.	005	11707	
	Bhysici	an	1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea	ath Day	Year		
	Physici /Medic	al	ROLAND	С.		SCC			riving a Constant	Decomo	- T	2005 County of Dea		-
	Examin	er	4a. Facility Name (If not institution, give				4b. City	Town, or Loca	tion of Death		4C. (	Lounty of Dea	un .	
			5. Social Security Number 6. S	al Medical ex 7. Age	(In yrs. la	ast birthday)			nder 24 Ars.	8. Date of Birt	h	9. Bir	thplace (State or Foreign	-
	Funeral Director			<b>™</b> 2□F	82	Yrs.	Months	Days Ho	urs Min.	(Month, Da MAY 17,	192	3 Di	ELAWARE	
	2		Usual Residence of Decedent		100 City	, Town or Lo	antion						10d. Inside City Limits	_
	ehow	_	10a. State 10b. County	Military									1 ☐ Yes 2 No	
	28a-1	Directo	DELAWARE SUSSEX  10e. Street and Number			RANKFO		o Code			10g. Citiz	en of What C	ountry?	-
3	ours after death with the Maryland rat', or items 23a or 28a-f ehow Examiner must be motified at		28132 CYPRESS I	ROAD				19945			_	USA		
	ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. \	Nas Dece	dent of Hispan	ic Origin? (Sp	ecify Yes or No Rican, etc.)	- 1	4. Race - Am Black, Whi		-
	or ite		1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 N If Yes, Give			ires, spi 1 □ Yes		ecify:	riodii, etc.)		0 4		
21215-0036	hours after tural", or ite al Exemine	d by	3 Widowed 4 Divorced	Year or Dates: J	1943-	45						W	HITE	_
7	"nati	ete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of w	ial Occupation ork done during ise retired)	most of work	ing	160. KI	d of Business	sylindustry	
12	within 72 ene. then "nat he Madic	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			PERATO	R		RE	TAIL C	LOTHING	
	be filed in the filed of the fi	Be C	17. Father's Name (First, Middle, Last,	)	1			18. 1	Mother's Nam	e (First, Middle,	Maiden .	Sumame)		
<u>a</u>	Q 50 0 0	To B	ROLAND F	•	SCOTI	[			SARAI	I	Мс	CABE		
Maryland	s 1 and 2 should by f Health and Menta ftem 27 ie marked other treumatic ev		19a. Informant's Name/Relationship (	Type, Print)		7				al Route Numb				
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ore	00		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	Cé	lace of Dispo emetery, crer	natory or	other place)		4		cation - City o		
Ē	permit. Pages Depertment of Importent: if it eny injury or o once.		4 ☐ Donation 5 ☐ Other (Specif	y)	RE	EDMEN'			12/8	/05	SEL.	BYVILLI	E, DELAWARE	
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	10.		scvd						Interval Between Onset and Death	
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9 ×	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incy					2	3d. Date of d	elivery	
.O. Box	atten atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal	death 3	]Ectopic ] Other (:	pregnancy specify)				Month	Day Year	
o.	that the de ned by the a detached f	lys	1  Yes 2 No 9 Unknown	9□ Unknown										
α <u>΄</u>	res that igned to be det	by P	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying	cause given in	Part I.	1		_	to the cause of death?	
ğ	w require been sig should b	g								10	Yes 26	⊒Mo 3 □ F	Probably 4 Unknown	
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Vital Records,	Physician: The law ribis certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only				
	Physi this o	2	1 P⁴fes 2 No 27. Manner of Death	1 L Inpatie		ÆR/Outpatie 28b. Time o		JUA 4	☐ Nursing H	ome 5 Resi			ecify)	-
ПО	ding h. After funer	달	1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes	2  No			,		
Division of	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj			reet, facto	ory, office					Rural Route Number,	
á	elor A after i Dire d in by	Full	4 Homicide	building, et	c. (Specit	<b>y</b> )				City or To	wn, State	/		
	ospit hours unera ly fille		33a. Cartifier 1 Gentifying P	hysician. To the best miner: On the basis o	of my kno	Wiedge, deat	h accume	c'at the time, d	ata and plana	and due to the	rause(s)	and manner	as stated. ue to the cause(s)	
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific gempletely filled in by the funeral director.	Medical	one)	and manner st		on and/or if								_
	of the state of th	2	29b. Signature and title of certifier				2	9c. License nur				e signed (Moi	nth, Day, Year)	
	7 nul	9	1 Chu In	N )				42040	1/		14	[ 7] 03		
	IVA		30. Name and address of person who	À	leath (Iten	n 23a) (Type,	Print)	+ Snl	chim.	md.	210	8) 1		
	St.	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature	100	SL1711	- puny	1116	x15	<u>~ (</u>		-
	Regist		DEC 0 7	2005	10.45 A	M. A	had	1						

222-10-9965

State of Maryland / Department of Health and Mental Hygierre 0 0 5 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 2003 4:36 PM **Physician** Smith Raymond Luther /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 7008 Kelly's Store Rd. Thurmont 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day Year) April 30, 1918 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number Funeral 87 Yrs. 220-16-0868 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter If Item 27 is marked other then "natural", or Items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Thurmont MD Frederick Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 21788 7008 Kelly's Store Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Øyes 2 □ No If Yes, Give Year or Dates: 1944-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) track foreman railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie Mae Young William Clinton Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 7008 Kelly's Store Rd., Thurmont, MD 21788 Tammy L. Deneale - granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. ō Rocky Hill Cemetery 12/2/2005 Woodsboro, MD ' 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens Woodsboro, MD 21798 404 S. Main St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 06 Structive **Physician** これるかいひ disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed peen s 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death Certification: After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital or within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11-29-05 MD MO 5160 MJL Michael Tolino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Aue 2170 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

		1	For Stata Registrar	10030	State of			Depai		of H	ealth a		Mental Hy	giene	1115	4145	9
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	Examin	<b>U</b>					ation			erli					Worces	ster	
			Berlin Nursi: 5. Social Security Number		Sex Renau	7 Age	(In yrs. last bi	inth da v)	If Under		If Under:	24 Hrs.	8. Date of Bir	h		irthplace (State or For Country)	reign
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John P Maryland 21215-0036	and 2 should ealth and Men n 27 le marke ser treumatic	ပ္	19a. Informant's Name/Re				10	h Mailin	a Address	(Street a			rai Route Numb		or Town. State	Zip Code)	
Jo	2 st and le n reun																
•	and lealth m 27 her t		Michael Ste				SON Place		10.000		St.,	Dur	rango, C		31301 ocation - City (	or Town, State	
Stengel Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 le marke eny injury or other treumatic 0008.		20a. Method of Disposition 1 ☐ Burial 2 ★Crem		☐Removal from	n State	cemet	ery, crem	atory or o	ther plac							
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at e	permit. Departr Importe eny inji		21. Signature of Funeral S	ervice Lic	ensee								nomas Fu			-141	
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ds,	uires that the signed by	by	Part II. Other significant of	conditions	s contributing to	death bu	n not resulting	) BI (III) GI	idenying c	ause giv	eri II) Fall				□No 3□	S.	
I Reco	sicien: The law requir s certificate has been si lirector, page 2 should	Completed											24a. Was auto perf 1 \( \text{Yes}		prior t death		lable e of
/ita	Physicien: r this certificated ral director,	Be	25. Was case referred to examiner?	medical	Hospital:					Oth	1		ath (Check only				
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0 0	ng Ph fter thi neral	no:	27. Manner of Death	Pending	28a. Dat (Mo	te of Injur onth, Day	Year) 28b	. Time of Injury	- 1	28c. Injur Wor	k?		28d. Describe	now inju	iry occurred		
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:5	el or Attending Pt s after death. el Director: After the	tific	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not determine	200. Fla	ce of Inju Iding, etc	ry - At home, :. (Specify)	farm, str	eet, factor	y, office			28f. Location City or To			Rural Route Number,	
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	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one)	Certifying ledical Ex	aminer: On the	the best of basis of anner sta	examination a	lge, death and/or inv	h occurred vestigation	at the tir i, in my o	me, date a pinion, de	nd place ath occu	a, and due to the irred at the time	cause(s date an	s) and manner od place, and c	as stated. lue to the cause(s)	
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			30. Hame and address of	person wh	no completed ca	use of de	eath (Item 23a	a) (Type,	Print)	Ces	esta	P 1	Legling	6	Ewick	Isl, P,89	*GRI
	St Regist	ate	31. Date filed (Month, Da	DEC (	7 2003	. Registra	eath (Item 23a	J.	Loc	de			4 /				
						- 1			-			-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** James Edward Stewart, Jr. 2005 /Medical 4a. Facility Name (If-not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University specialty Hospital Baltomore Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y 1-6-1951 **Funeral**  Birthplace (State or Foreign Country) 1 ■ M 2 □ F 214-58-0149 54 Yrs Director Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22846 Colton Point Road 20618 items 23a United States Completed by Funeral 2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ■ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward Stewart, Sr. Clara Louise Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 is any injury or other tre once. P.O. Box 22, Bushwood, 110 20618 se of Disposition (Name of 20c. Veronica Miles/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Charles Memorial <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 12-16-2005 | Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road, Leonardtown, MD 20650 Kyle S. Simons M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End stage chronic chstructive Lung disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (o. as a consequence of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit ding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Osteoporenis and ventehral Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Punknown dependenciont 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy 2 12 No 1□ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Denpatient 2 EP/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/12/05 D 30494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP alago K DESAI GOI SOUTH Charles street Baltimore USH 31. Date filed (Month De Ceal 5 2005

DHMH 17 Rev 1/2001

State Registrar istrar's Signature

32. F

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 9:55 December 12, 2005 Leroy Joseph Stockero, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Marv's Leonardtown If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 58 Director 365-46-7824 Michigan September 1,1947 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r than "naturel", or items 23s or 28s-f show the Medical Exercit or must be rediffed at 1 ☐ Yes 2 No Director St. Mary's Lexington Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21460 Bellevue Court 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government a filed within 7 at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Computer Networking Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H 7 Is marked ott Joseph Stockero Edith Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 21460 Bellevue Court, Lexington Park, Maryland 20653 Marianne Stockero / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
The City of Mesa 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State December permit. Page Department Important: If eny Injury o 4 ☐ Donation 5 ☐ Other (Specify) 21, 2005 Cemetery Mesa, Arizona 21. Sign at e of Fune at Service Lices 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock; or heart failure. List only one cause on each line. 23a, Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastalic **Physician** /Medical Examiner mass enal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the burial-transit ASCI Due to (or as a consequence of) Box 68760, Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 - Homicide ō within 24 hours a To the Funeral E the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 47066 gran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 404, Leonardtown, Maryland 20650 Avani D. Shah, M.D. 22650 Celar Lane Court, 31. Date filed (MDE Cay 1 4) 2005 Registrar's Signe ure State Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 4, Thomas Dexter Strong Dec. 2005 12:50 pm · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis If Undar 1 Year | If Under 24 Hrs. | 8. Date Months | Days | Hours | Min. | C. (Mor.) Anne Arundel 8. Date of Birth (Month, Day, Year) Sep. 15, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 73 Director <u>366-30-4012</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 Finneans Run 21012 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours efter 10 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within." h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Secret Service Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Depertment of Health and Mental important: If term 27 is marked o any injury or other transment. Marlin B. Strong Helen May Tefft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Strong/Wife 1210 Finneans Run, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Dec. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2005 21. Signature of Funeral Service Licenses \_22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 3 months disease or condition resulting in death) Examiner to (or as a consequence of): Examiner 2 be executed the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 should 24a. Was an autopsy performed? RUNARU 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical/ 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tes 2 UNO 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hatural 5 Pending death. investigation 1 Yes 2 🗆 No 2 ☐ Accident after death completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the Vithin 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 7965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month

7 2005

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

			State of Maryland /  Por State Aggistrar	Department of Health and Me Certificate of Death	•	2005 41463
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Joseph Vincent Slechta 4a. Facility Name (If not institution, give street and number)  Berlin Nursing & Rehab. Center		ecember	Oay Year 3. Time of Death 2:45 A M  4c. County of Death Worcester
	Funeral Director		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	rirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1	8. Date of Birth Month, Day, Yes 1/13/1921	9. Birthplace (State or Foreign Country) MD
l	e Maryland 3a-f ahow Lifted at	ctor		ean City		10d, Inside City Limits 1 ⊠Yes 2 ☐ No
	sath with the s 23a or 24	Funeral Director	10511 Keyser Pt. Rd.	10f. Zip Code 21842		Citizen of What Country? USA
9200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. In Internative in the XI is marked other than "natural", or Itams 21a or 28a-f ahow any injury or other traumatic avent, the Medical Examinar must be notified at once.	þ	11. Marital Status  1 □ Never Married  2 □ Married  3 □ XWidowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Xyes 2 □ No If Yes, Give Year or Dates: 1943 - 46	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2 ☒ No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
121	be filed within 72 h tal Hygiene. d other than "natu avent, it e Miclical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Machinist	9	Kind of Business/Industry  Steel Industry
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હ ≔	nit. Pages artment of I ortant: If its injury or of			of Disposition (Name of ery, crematory or other place) eterans Cemetery 12/8/ 22. Name and Address of Facility The	′2005 H	Location - City or Town, State Urlock, MD Uneral Home
S1 Ba	permit. Departr Imports any inju	1	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause of each line.	108 William St., Ber	lin, MD	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to Jas a consequence	M Lynghor	e	Onset and Death  Ceso-s'
	ysicia	Ical Ex	Sequentially list conditions, if any, leading to immediate cause. Lifety underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence cause). The consequence cause of the consequence cause of the consequence cause. The consequence cause of th			
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Division of Vital Records, P.O	ding h. After fune	atlon: To Be	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation			6  ☐Other (Specify) jury occurred
Divis	i Sign	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)	<u> </u>	City or Town, Sta	
	To tha Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge of the basis of examination a and manner stated.  2 Signature and the of certifier	ge, death occurred at the time, date and place, an ind/or investigation, in my opinion, death occurred 29c. Licanse number	d at the time, date a	(s) and manner as stated.  Indiplace, and due to the cause(s)  Date signed (Month, Day, Year)
	+ ≯ F 8		30 Name and address of person who completed cause of death (Item 23a	D 708%	7	12 /6 /05
ET	0+1 Sta	te	Michiele N. Berbluce, vol. 31. Date filed (Month, Day, Year) 2005   32 Registrar's Signature	1209 Coustellylu	vez C	2 19949
	Registra	ar	DEC TO LOSS			

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ORIGINAL

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	Physici	an	Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	ath Day	Year	3. Time	of Death
	/Medic		Emma P. Segato				1				Decem	ber 4,	2005	2:10	рм
	Examin	er	4a. Facility Name (If not institution, give Holy Cross Hospit		,				Sprir				nty of Death		
	Funnal		5. Social Security Number 6. Se		ne (In vrs.	last birthday)		r 1 Year	If Under		8. Date of Birt		tgomer		or Foreign
	Funeral Director			□M 2\\ F	82	Yrs.	Months		Hours	Min.	(Month, Da)	v, Year)	Ita		or Foreign
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<u></u>	shoul nd M mari	F	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Addres	s (Street a			Il Route Numbe		vn, State, Zip	Code)	
Ě	elth a		Patricia S. Walke	er/ Daugh	ter						er Spri				
ב פ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene.  Department of Health and Mental Hydiene.  By Interpretative from 27 is marked other then "naturel; or lieme 23a or 28a-f ehow any interpretation at the motified at once.  Once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Domaval from State		Place of Dispo	sition (Na	me of other place	е)		mber 8	20c. Locatio	n - City or To	wn, State	
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	5		Vandau (	. Wil	nn	10		000	619.	37		12	- /4/6	5	
			30. Name and address of person who o	ompleted cause of	death (Iten سر ر	n 23a) (Type,	Print)	- /	100/6	67	<	201	214//	202	2001-
P	Sta	te	CANDACE L. WIL  31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	NESI	6-6	EN	0,	SILVER	SPR	ING	1111) 5	0110
	Registr		DEC 0 8 20	J5 132 4	1	Agent									

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BETTY HELEN TISCH December 2005 4:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fairland Nursing & Rehabilitation Ctr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1□M 2\ F Director 236-54-6983 69 1936 West Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7015 Highview Terrace #203 20782 U.S.A. Completed by Funeral fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Southern Elementary/Secondary (0-12) College (1-4or 5+) Leasing Consultant Maryland Apartments permit. Pages 1 and 2 should be flit Deportment of Heelth and Mental Hy Important: if Item 27 is marked oth any injury or other treumstic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Simmons Besie Pearl Patch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Rinker - P.O.A. 6701 Park Hall Drive, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/8/2005 Alexandria, Virginia 21. Signature of Furneral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Minno Cany 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Ovarian Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the ettending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? res 2 X No certificate 2 No 1 ☐ Yes 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death |Check only one Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 December 7, 2005 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 1517 Hugo Circle, Silver Spring, Maryland 20906-5917 MD Alan R. Segal, 31. Date filed (Month, Day, Year) State Registrar DEC 0 8 2005

DHMH 17 Rev 1/2001

		٠.	State	partment of Health and Mental I ertificate of Death	C000 41400
. 29		2	Registrar Amended 8,12/7/05,LDB,DOR Co	2. Date of	
*	Physici /Medic		THEOLA S THOMAS	Month	EMBER 1 2005 916 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	200	×.	Upwensory or Mancan's Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BACTIMONE  If Under 1 Year If Under 24 Hrs. 8, Date of	f Birth JN 22, 1340 irthplace (State or Foreign , Day, 1991)
(#) (E)	Funeral Director		219-36-6353 10 M 200F 65 Yrs.	Months Days Hours Min. (Month	
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d, Inside City Limits
_	Maryland f show lied at	tor	MD Talbot Roya	- 1 - 25 - 2	1 12 Yes 2 □ No
7	or 28a	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
0	death with	ralD	5690 Gate Street	21662	USA
R	b = =	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ ✓	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> </ol>	r No- 14. Race - American Indian, Black, White, etc.
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ylar	2 should be and Mental Is marked aumatic ev	ToE	Frank Gibson	Louetta	Hdams
Maryland	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		C \ 1100001 F16	ailing Address (Street and Number or Rural Route No	Cak, Maryland 21662
			20a. Method of Disposition 20b. Place of Disposition	sposition (Name of Date rematory or other place)	20c. Vocation - Oity or Town, State
о Ш	Page nent o ant: If ary or		1 MBurial 2 ☐ Cremation 3 ☐ Hemoval from State	Mem. Park 12/7/05	Easton, Maryland
Baltimore,	permit. Pag Department Important: eny injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	/ /
	20 = 0 a		23a. Pakr. Enter the disease, or complications that caused the death. Do not a	Henry Funeral Home, 510 washington Str Co	ambridge, MD/2/6/3
U.S.	Physician		shock, or heart failure. List only one cause on each line.	1	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)  a. Anoxic Brain  Due to (or as a consequence of):	NZURY	
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	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MAL DISEASS	
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8760,	cate be	dical	d DIABETES		
9	Attending Physician: The law requires that the daath certific cleath. sctor: After this certificate has been signed by the attending protor: After this certificate consider the sector. After this certificate has been signed by the funeral director, page 2 should be detached for use as	0	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
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COL	w requir been si should	iete		24a.\	Was an 24b. Were autopsy findings available
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Vital Records,	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Check o	
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Division of	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)
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	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, de (2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the ti	ime, date and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and filte of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Pierki, MI	> P19764	DECEMBER 15 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type Argustry Low 10 E. VEC 57 #17073	_	
57	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Regist	ar	DEC 0 7 2005	Corelle 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Tilghman 30 0959AM 4a. Facility Name (Wnot institution, give street and number) NOV. 2005 vard /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex Canlor da If Under 1 Year If Under 24 Hcg. Months Days Hours Min. Ral HOSP, tal 7. Age (In yrs. last birthday) General Dorchester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-16-880 10M 2□F Virgini Director Usual Residence of Decedent deeth with the Marylend 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits il Hygiene. other than "natural", or Itama 23a or 28a-f ahow vant, ira Madical Examinar must be notified at 1 Yes 2 □ No Director )orchester ambridge 10e. Street and Number 10f. Zip Gode 10g. Citizen of What Country? 70 2161 USA Sh Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. permit. Peges 1 end 2 should be illed within 72 hours elter d Department of Heelth end Mentel Hyglene. Important: if Itam 27 Ia marked other than "natural", or Itan Important: if Itam 27 Ia marked other than "natural", or Itan May Injury or other traumatic avant, the Medical Exeminat. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify Specify: 3 MWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Furniture Store Entre Preneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OSCAY TIGHMAN

19a. Informant's Name/Relationship (Type, Print) Beulah-Ma Jor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philadelphia Maily
Date 20c. Location)- City or Town, State 0 123 Kerper Janelle lark 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removel from State Cambridge 10/05 Cemetery \* 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Howey Funeral Home, P. A.

23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician preumon/a day aspiration /Medical Due to (or as a consequence of): Examiner 2 months phog 12 chronic 5 dy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed sate has been signed by the ettending physicien and page 2 should be deteched for use as tha buriel-trensit 34eaus Chronic renal Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ementia Be Completed 24b. Were autopsy findings available prior to completion of cause of death? hypertension 24a. Was an After this certificate hes i autopsy performed? 1 ☐ Yes 2 3 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€10 Certification; To 27. Manner of Death 1 (INatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident within 24 hours efter deet! To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 nedn 140059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month)

100 Bramble

32. Registrar's Signature

Johnson

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Cambridge

			1 - For State Registrar	State	of Maryla				ealth a Death			jiene	05	41468
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Unde	r 1 Year	If Under		8. Date of Birth (Month, Day	1		olace (State or Foreign ntry)
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	and and		Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. C	City, Town or Lo	ocation						1	10d. Inside City Limits
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Saltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 le any injury or other trau <u>2005</u> 9.		21. Signature of Fureral Service		4						P.A.,			
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	6		30. Name and address of person											
			J. Garrett ]	Reilly, M.	D. 34 Pigistrar's Sign		ndwoo	d Cou	ırt,	01ne	ey, Mary	land :	20832	
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DHMH 17 Rev 1/2001

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	/Medi	cal	Barbara J. Utl								r 2, 200!		7:40	<b>p</b> • M
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "netural", or Items 23e or 28e-f show any Injury or other traumatic avant. Its Madical Examilia is must be neitling at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	ces? 2 (2/No		Was Decedent f Yes, specify 1 ☐ Yes 2 ☐		anic Orig Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race Black Specify:	- America c, White, e		
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altimore,	Pages 1 and 2 nent of Health a int: If Item 27 Is iry or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		tate	Place of Dispo cemetery, crem restda	natory or other	r place)	v 12	Date 2-8-2005	20c. Location - 0			
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	Pnysician /Medical Examiner	66	Immediate Cause (Final disease or condition resulting in death)	a. Pr	way rasachsed	****	rafive	Dei	иси	Ka		>	Interval Ber Onset and > 2 47	Death
	ed sit	niner	Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a conse	ineuce of:								
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	To the Hospital or Attanding Physician: within 24 hours slier deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)  1 Certifying F	hysician: To the basing manner	sis of examina	owledge, death ation and/or inv	occurred at the	ne time, my opini	date and ion, death	place, and due to the cocurred at the time,	cause(s) and mandate and place, ar	ner as stat id due to th	ed. he cause(s	;)
)	To the within 2 To the complet	Me	29b. Signature and Ittle of certifier	1			2	208	2157		29d. Date signed			
	6		30. Name and address of person won	completed cause	of death (Iter	n 23a) (Type, I	Print) L(At)	RTY	RO	ElDi	PSAURG.	ws	2178	4
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32.	gistrar's Signa	ture 4	sole			ElDin				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December/1/2005 **Physician** 12:25 p M MARIA ROSALINA VELASQUEZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CHEVERLY PRINCE GEORGE MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign EL SALVADOR 8. Date of Birth , Funeral 1 ■ M 2 🕱 F 09723/1923 Director 213-96-9467 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits r then "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at Director 1 XYes 2 □ No MARYLAND PRINCE GEORGES BLADENSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EL SALVADOR 20710 5417 UPSHUR ST. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: El Salvador Specify: HISPANIC 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOME MAKER 6th traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H lant: If Item 27 Is marked ott Be ANTONIA VELASQUEZ UNKNOWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BLADESBURG, MD 5417 UPSHUR ST. DORILA GOMEZ (DAUGHTER) or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If eny injury or once. 12/9/2005 GATE OF HEAVEN MD, SILVER SPRING 21. Signature of Funeral Service Licenses Name and Address of Facility Santa Cruz Servicios Funerarios, 1N 600 Kennedy ST. N.W.: WASHINGTON, D.C. 20011 23a. Part1. Enter the diseas or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CIVINOSOS /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, hay, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a consequence of): Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 P/No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Watural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital within 24 hours e 1 20 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 046093 mo, pho 30, Name and address of occupleted cause of death (Item 23a) (Type, Print) Radman MosTaghim 7305 Hanover Pulkway, Grunbelt MO 30770 31. Date filed (Month, Day, Year) State DEC 0 8 2005 Registrar

			For State Registrar		State of	Marylar				lealth a Death	and Me		jiene 1eg. No.	005	The state of the s	71
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	ne 23	era	11. Marital Status		12. Was Deced	ent Ever in U	J.S. 13.	Was Dec	edent of H	ispanic Ori	gin? (Spec	cify Yes or No-	,	I. Race - Ame	ncan Indian,	
	fter d	듄	1 ☐ Never Married 2 🖾 Mar	ried	Armed Forc 1 ☐ Yes 2			If Yes, sp	ecity Cuba	n, Mexican	, Puerto R	lican, etc.)		Black, White	etc.	
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	B		The Court	0	120			¢	000	75	074		12/	1-100		
	6		30. Name and address of person	who co	mpleted cause		<b>)</b>			St.	P.	1.1.		1-1	- 21804	,
	<u> </u>		31. Date filed (Month, Day, Year	MC		istrar's Sign	.,,,,	1 J.	m.	44,	Mal	ころろう	14	na	C (KOY	,
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553-38-7657

JENNIE M. Vollmer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** December 2005 5:10 p<sup>M</sup> Edna Marie Vickers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Caroline Homestead Manor Denton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Days Hours Yrs. 1908 Kansas 214-07-7487 97 Director 24, Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Marylar Itams 23a or 28a-f show the Medical Examiner: ust by notified at 1⊠Yes 2 No Dorchester Cambridge **Funeral Directo** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 109 Rambler Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 XNo Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) garment seamstress other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is markad oth any ligury or other traumatic evant 2008. Be August F. Knauer Margaret Fessler 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Choptank Dr., East New Market, MD Donald Knauer nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Dorchester Memorial Park 12/5/05 Cambridge, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneymonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, λ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted 1 □ Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Matural 5 Pending s after death.

I Diractor: Af
id in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a To tha Funaral I The descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD V6053255

State

Registrar

Lednum

Preston

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

136

32. Registrar's Signature

Butter

**DEC 0 6 2005** 

Melinda

31. Date filed (Month, Day, Year)

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State of Maryland	/ Department of Health ar	nd Mental Hygieneć 🔱 🧯	J

		1	State of Maryland / Dep.  1 - State Registrer Ce	artment of Health and M rtificate of Death	lental Hygie	
i.	Physicia	_	Decedent's Name (First, Middle, Last)     Yvonne Walker		2. Date of Death Month November	29,2005 3. Time of Death 9:13 P. M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)  P. G. Hospital	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's
pg.	Funeral Director	•	1 • G • HOSPICAL  5. Social Security Number  243-88-1239  6. Sex 1□ M 2♥ F  7. Age (In yrs. last birthday, 52 Yrs.	- L	8. Date of Birth (Month, Day, Ye August 4	9. Birthplace (State or Foreign Country)
	laryland ehow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  MD Prince George's Landover			10d. Inside City Limits 1X∑Yes 2 ☐ No
	with the N la or 28e-f Le notifii	Funeral Director	10e. Sireet and Number 7120 Kent Town Dr.	101. Zip Code 20785		Citizen of Whal Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinal must be notified at ance.	by Funera		Was Decedenl of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036	within 72 hou ane. than "natura to Medical E	Completed	(Specify only highest grade completed) (Givilife.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) 1es Manager	ring	b. Kind of Business/Industry
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Baltimore,	ages 1 an ont of Heal tr: ff Item 2 y or other		20a. Method of Disposition  1 St Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of ematory or other place)	Date 20	c. Location - City or Town, Slate uantico, VA
Baltir	permit. P Departme Importan any injur once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ft	. Lincoln	Funeral Home
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8760,	Medical Examiner ophisician and the purial-transit the purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	anyngeal Co	was w	na
.O. Box 68	death certific e attending p d for use as l	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
σ.	es tha gned be de	ē	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 ☑ ¶0 3 ☐ Probably 4 ☐ Unknown
Records	he law e has b	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vital	ician: certific	o Be (	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient	Other	th (Check only one)	ce 6 □Other (Specify)
of	ding h. After fune		27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 22. Exhibiting 2 Accident 22. Exhibiting 2. Exhib	of 28c. Injury al	28d. Describe how	
Division	P in in	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, so building, elc. (Specify)		City or Town,	
	To the Hospitel (within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de. (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within 2 To the comple	M	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
2	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type			1/00/2005
1	St	ate	3001 Hospital Drive	Cheverly, MD 20	781	
	Regist		DEC 0 8 2005 Slave & April	ME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 5 For 12-8-05 State of Maryland / Department of Health a State Registrar Amend#23aPrt.1 & II Per Phys.PGCcrCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Julia F. Wilson /Medical November 29. 2005 7:15A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Summerville at Woodward Estates Bowie Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 □ M 2 🖾 F 70 Director 578-44-7574 Dec. 9, 1934 Washington, DC Usual Residence of Decedent 10a. State r than "natural", or items 23s or 28e-f show The Modical Expressional be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George Maryland Capitol Heights 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 117 West Mill Avenue 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black à 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked ot Robert Fields Maggie Marcus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Cozet Grice-Winston/Daughter 117 West Mill Avenue; Capitol Heights, MD. 20743 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Dec. 3, 2005 Brentwood, MD. 21. Signature of Funeral Service Licenses Pope Funeral Homes 5538 Marlboro Pike 22. Name and Address of Facility Forestville, MD. 20747 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiopulmonary Arrest /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sudden Death Examine the death certificate be executed Atherosclerotic Vascular Disease the burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical Hypertension as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Recent Cerebral Vascular Accident Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus Type II autopsy performed? Yes 2 No page Seizure 1 Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: P 1 🗌 Inpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral Certification: 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No 3 T Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ŏ filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 the 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) D0038149 December 2, 2005 Regett & how m 5 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) Susan Leggett-Johnson, M.D. 6525 Belcrest Rd., Hyattsville, MD. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Watters avid 0653 AM 28,2005 November /Medical 4b. City, Town, or Lucaus.

CMCS + V + OWN

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

November 14, 1942 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Kiver 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1∰M 2□F 63 191-34-7185 Director PA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, Ite Medical Exam is entured. MD Queen Anne's Director Church Hill 1 ☐ Yes 21 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Crane Swamp Road 21623 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 A No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Manager Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Chester Watters Katherine Lambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Watters/wife 511 Crane Swamp Road, Church Hill, MD 21623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Riverside Cemetery Dec.2,2005 Norristown, PA `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam 130 Speer Road, Chestertown, Funeral Home, P.A. MD 21620 ch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician TOIST /Medical Due to (or as a consequence of): 1-2415 **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): burial-P.O. Box 68760 the attending physician Physician/Medical as the for use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown Š signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 X No Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗖 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 😿 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051786 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 Pennsylvania Are, Centreville, MD 21617 Sanina 31. Date filed (Month, Day, Year) 32. Register's Signature State 3 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stata	State of Maryland		ertificate of I		ental Hygie	<b>20</b> 005	41476
			Registrar  1. Decedent's Name (First, Middle, Las	t)	- 0	er linicate or i		Rag 2. Date of Death	. No.	3. Time of Death
	Physici /Media		Gertrud	e Wi	111	am.s	h	Nonth levember	Day Year 200:	55:05 PM
	Examir		4a. Facility Name (If not institution, give		,		Location of Death		4c. County of Dea	
			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	neval Hospita	/	(Q-M)			Dorche.	ster
	Funeral Director		5. Social Security Number 6. Se 2 2 0 - 10 - 6 387	7. Agle (In yrs. la	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Y	1 1 1 1 1 1 1 1 1	thplace (State or Foreign
	_		Usual Residence of Decedent	00		<u> </u>		1-eb. 22	,191/1//	rginia
	arylar show	_	10a. State 10b. County	10c. City,	Town or	Location				10d. Inside City Limits 1
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4	3e or	0	701- Race S	treet Apt	116	2	1613	109	1154	L
0	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13	. Was Decedent of Hi	ispanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No-	14. Race - Ame Black, Whit	rican Indian,
36	72 hours after death with the Maryland neture!', or Items 23e or 28e-f show iteal Examinar must be redified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 1⊉No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	ioan, etc.)	Specify:	1
5-0036	72 hours "neturel", dical Ex	ed b	15. Decedent's Ed	Year or Dates:	16a. Dec	edent's Usual Occupa	ation	16	b. Kind of Business	1ack Industry
215	C 2	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Giv	e kind of work done o DO NOT use retired	during most of working )	7		
21	filed with Hygiene ther the	Соп	3		Pro	essing L	18. Mother's Name (	Ken &	seafou	d Factory
Maryland		Be	17. Father's Name (First, Middle, Last)	101 1000		5	18. Mother's Name (		,	,
Ž	2 should and Me Is mark eumatid	င္	Archie A	tolden	19b. Ma	ling Address (Street a	and Number or Rural			V Zip Code)
	rtr		Wilmore	Holden	41	7 W:111	s St. C	ambr	dae MI	2/6/9
Baltimore,	es 1 a of He of Hem fitem r othe		20a. Method of Disposition  1 De Burial 2 Cremation 3	20b. Pla	ice of Disp metery, cr	osition (Name of ematory or other place	Da Da	te 20	c. L xo tion - City or	Town, State
Ë	nit. Pag vartment ortent: I injury o		* 4 ☐ Donation 5 ☐ Other (Specify	Be	the	Cemete		05 C	ambric	Lac, MD.
Ball	permit. Pages 1 are Department of Hea Importent: If item any injury or othe	1	21. Signature of Funeral Service Licens	C. Henry	. 2	22. Name and Address HENRY FU	NeROL H	ome, P. A	4.	10.2/6/3
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death.	Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a ASPIRA	7701	PNE	Umoni	A		24 hours
	/Medical Examiner		Toolaning in double	Due to (or as a conseque	ence of):					
	÷	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):					
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events	c						
60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
68760	ficate physics the l	edlcal		d.						
Вох	eath certif attending for use as	m/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of		□Ectopic pregnancy			23d. Date of del	very
	e deati the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of dea		Other (specify)			Month	Day Year
P.0	hat the de ed by the detached	Phy	Part II. Other significant conditions co	intributing to death but not result	ting in the	underlying cause give	on in Part I	23e. Did tobac	co usa contributa to	the cause of death?
Division of Vital Records,	The law requires that the death certificate be execut the has been signed by the attending physician and bage 2 should be detached for use as the burial-tran	d by	HYPERT			, , , , , , , , , , , , , , , , , , , ,		1 ☐ Yes	2 □ No 3 □ Pr	obabiy 4 🛮 Tinknown
O 0	aw requir as been si 2 should	Completed	CONGESTI	VE HEART	-	FAILUR	E	24a. Was an	24b. Were au	topsy findings available
R		Com						autopsy performed 1 Yes 2		completion of cause of 2 No
Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		othe Othe	26. Place of Death (			
ō	g Phys er this eral di	To tu	1 Yes 2 No  27. Manner of Death	I Inpatient 2416	R/Outpation 28b. Time	III 3 DOA	4   Nursing Home	5 Residence d. Describe how	e 6 Other (Specinium occurred	sify)
ion	te A h	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		:? /es 2 □ No			
Νį	or Atterder ter de irecton by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, s	treet, factory, office	28	f. Location (Stree City or Town, S	t and Number or Ru State)	ral Route Number,
Ω	e Hospitel or Atten 24 hours after deatl 8 Funerel Director: etely filled in by the	Ce	29a. Certifier 1 Certifying Phy	sician: To the best of my knowl	lades des	Ala a a a a a a a a a a a a a a a a a a	- 4-1 4-1		-()	
	e Hos 24 hc e Fun letely	edical	(Check only one)	iner: On the basis of examination and manner stated.	on and/or i	nvestigation, in my op	e, date and place, and inion, death occurred	at the time, date	e(s) and manner as and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	1-10-11	·· <u> </u>	29c. License	number	29d.	Date signed (Month	i, Day, Year)
			1/lest	La Vai		DO	05186	5 N	OVEMBE	n 30, 2005
			30. Name and address of person who c	ompleted cause of death (Item 2	23a) (Type	, Print)	2 LENIO	100 1	CAN.	MBRIDGE, MD
	Sta	te	31. Date filed (Month, Day, Year)  DEC 0 5		re	I A	- 6.0146	1-150	פרק וקצטו	
	Registr		DEC 0 5	2005 Mesur	B,	grade				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year Michael Wayne Weston, Sr. 4:25 p M /Medical DECEMBER 14 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deat Examiner St. Mary's Hospital Leonardtown St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 2-6-1944 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 □ F 61 Yrs. 218-42-0971 Washington, DC Director Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Exer-ther must be notified at Director 1 ☐ Yes 2 ■ No St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45899 South Springstein Court 20619 or Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced 'natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic evant, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Authur Weston Rosalie Charlotte Narrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45899 South Springstein Court, California, MD 20619 Margaret Weston/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State \* 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 12-17-2005 Charlotte Hall, MD 22. Name and Address of Facility Erinsfield Funeral Home, F.A. 21. Signature of Fundant 3 Trice Licensee 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Priysician TYPE 2 disease or condition resulting in death) HOUTS /Medical Examiner Hypovolumic Shock HOUSS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hours burial-transit Acute ornal Due to (or as a consequence of): Vital Records, P.O. Box 68760 attending physician OGStonegue SICET YEGIS . Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed HYPErtension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Seven cardiomyspatay 2 No 1 🗌 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 o 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a

State Registrar 29a. Certifier

29b. Signature and title of certifier

DHANANJAY V BHAVSAR

31. Date filed (Month, Day, Year)
DEC 1 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cal

DHMH 17 Rev 1/2001

MICHAEL WAYNE WESTON

Certifying Precian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SHAH ASSOC HOLLYWOOD MD 20636

29c. License number

120061719

29d. Date signed (Month, Day, Year)

12.15.05

State of Maryland / Department of Health and Mental Hygiere 05 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day Viola P. Walker 3 2005 December 2155 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb 5 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 214-05-1913 94 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Maryland Anne Arundel
10e. Street and Number
857 Spa Rd 1 ☐Yes 2 ☐ No Annapolis 10f. Zip Code 10g. Citizen of What Country? with ö 857 Spa Rd. Itams 23a 21401 USA death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural!" or other traumatic averages any injury or other traumatic averages. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify Black þ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Laundry Presser Ft. George Meade 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter B. Parker Sarah Unobtainable 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Lomax(Daughter) 217 Croll Dr. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Brewer Hill 1 N Burial 2 □ Cremation 3 □ Removal from State 12-9-05 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Larry St. Sees moo 483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached to 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 atient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred After Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical . 1 29b. Signature and title of certified 29c. License number 29d. Date signed (Month,/Day, Year) 30. Name and A dress of person who co let d cause of death (Item 23a) (Type, Print) emi 31. Date filed Month, Day, Year) 32. Registrar's Signature State DEC 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Flora Μ. Williamson 10:55 PM December 5, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 X □ F Yrs. Director 216-64-5669 90 April 20, 1915 Washington, Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rel', or Iteme 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Montgomery Maryland Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9910 Edgehill Lane 20901 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Iteme 23a eny injury or other traumatic event, the Maudical Examinant must. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: Specify: White δ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander McKenzie Jane Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Williamson/ Son 9910 Edgehill Lane, Silver Spring, MD 20901 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State December 9 Gate of Heaven Cemetery 1 Durial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signatur A Pineral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, che Kan MD 20901 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 4 **Physician** /Medical to (or as a donsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown een signed by te hould be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' certificate 2 🗔 🛭 1 Yes 1 ☐ Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death Check only one Other: 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check unity 29b. Signature and title of certifit 29c. License number 29d. Date signed (Month, D.J., Year 12 and address of person 30. Name. ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) strar's Signature State 8 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Marie Williams December 5, 2005 10:35 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring
If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. Holy Cross Hospital Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Oay, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F 577-26-3208 83 Yrs 15, 1922 Washington, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes ※☐ No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 3210 Norbeck Road, #102 20906 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Earl Simmons Cecile Loretta Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Simone/ Daughter 10212 Menlo Avenue, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State December 9 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Fureral Service Licensee rancis coulins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 open 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Days Due to (or as a consequence of): Pneumonia Days Due to (or as a consumence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease, Diabetes Mellitus, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Rheumatoid Arthritis

**Physician** /Medical Examiner

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Baltimore, Maryland 21215-0036

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10a. State

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11. Marital Status

10e. Street and Number

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5. Social Security Number

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

autopsy 2¥□ No 1 ☐ Yes

25. Was case referred to medical

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Kapatient 2 ☐ ER/Outpatient 3 ☐ DOA

2 No

1 Tos 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 | Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier ma mo 29c. License number

29d. Date signed (Month, Dev. Year)

Location (Street and Number or Rural Route Number, City or Town, State)

D32332

December 7, 2005

me and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Suresh K. Gupta, M.D. 9801 Georgia Avenue, #220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year)

Registrar

2005 08





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Please Type or	r Print in Black	k indelible ink.	Ensure All (	Copies Are	egible.
State	of Maryland / D	<b>k indelible ink.</b> Department of H	ealth and Mei	ntal Hygiene	000

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pletely filted in by the funeral director, page 2 should be detached for use as the but edical Certification: To Be Completed by Physician/Medical	1 F 23 25 27 29 29	is initiated events suiting in death) Last suiting in death) Last is suiting in death) Last is suiting in death) Last in the past 12 months?  1	23c. If yes, outcome of pregnancy 1	26. Place of De.  27. Dutpatient 3 DOA Other: 4 Nursing Holingry Mork?  M 1 Yes 2 No  Ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	24a. Was an autopsy performed?  1 Yes 2 Ath (Check only one)  1 Describe how in 28f. Location (Street City or Town, State and due to the cause aurred at the time, date a	Month  o use contribute to 2 No 3 Pro  24b. Were au prior to death? 1 Yes  6 Other (Special or Special he cause of deathabbably 4 Donknown topsy findings available ompletion of cause of 2 No  ify)  ral Route Number,  stated. to the cause(s)	

			1 - For State Registrar	State of Maryla		artment rtificate				Reg. No.	2005	and the state of t	183
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Month	Day	Year	3. Time of	
	/Medic		Dolores Faye Zamma								2005	1:45	a <sub>M</sub>
1	Examir	ier	4a. Facility Name (If not institution, give s		_			ocation of De	eath	4c.	County of Death		
			Montgomery Hospice  5. Social Security Number 6. Sex			If Under 1	ville	e f Under 24 F	frs. 8. Date of I	Rinth	Montgon	nery	or Foreign
	Funeral Director			M 280 F 76	V	Months				Day, Year)	Cot	untry)	-
			Usual Residence of Decedent			1			Journ	LO, L	za wes	st Virg	TilTq
	how	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside C	
	Ba-f	cto	Maryland Montgom	ery S	ilver	Spring	1					1 🗌 Yes	2 No
	ith th	Director	10e. Street and Number			10f. Zip (	Code			10g. Citi	zen of What Cou	untry?	
	ath w	ā	11600 Connecticut			209					USA		
	er de	Funeral		Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decede If Yes, specif	ent of Hispa fy Cuban, i	anic Origin? Mexican, Pu	(Specify Yes or lend Rican, etc.)	No-	<ol> <li>Race - Amer Black, White</li> </ol>		
36	hours after death with the Maryland turel', or iteme 23a or 28a-f ehow at Exactical count be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes 2	IX No S	Specify:			SpecifyWhit	.e	
9	2 hours	ed	15. Decedent's Educ		16a. Dece	dent's Usual	Occupatio	on .		16b. Kir	nd of Business/I	ndustry	
215	2 5 3	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work DO NOT use	retired)	ing most of v	working			,	
21		mo;	12	College (1-401 3+)	Hor	nemake	er				wn Hom	ie	
g	be filed ntal Hygi od other event, L	Be	17. Father's Name (First, Middle, Last)				18	B. Mother's h	Name (First, Midd	le, Maiden	Sumame)		
yla	Mental Mental arked c	10	Noah Javins					Maggi	e Holste	ein			
Maryland 21215-0036	2 shoul and Me ie mark raumati		19a. Informant's Name/Relationship (Typ						Rural Route Nun				
	1 and 2 Health tem 27 i		Louis John Zammar  20a. Method of Disposition		Place of Dispo		Control of the last		Data				902
Baltimore,	it. Pages 1 and 2 should b rtment of Health and Ments rtant: If item 27 is marked njury or other traumatic e		1 Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	cemetery, crer Lington 1	natory or oth	her place)	D	ec. 21,	200. LO	cation - City or T	own, State	
틆	Separtment mportant in y in jury in ju		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature 1 → neral Service Licens	1	_				2005		ngton,	Virgin	ia
Ba	permit. Departr Import. eny inju		1 Chatek	mee	F1	ancis 00 Uni	versi	collin itv Bl	s Funera	l Hom	e Inc	, MD 2	0901
			23a. Part1. Enter the disease, or complic	cations that caused the dea							ppring	Approximat	te
	Physician		shock, or heart failure. List only on Immediate Cause (Final	Metastatic	Endome	trial	Cano	or				Interval Bet Onset and I Years	Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse		or rar	Carre					iears	
	Examiner		Sequentially list conditions b										
	Sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):								
	be executed ician and burial-transit	хаш	that initiated events c.	Due to (or as a conse	quence of):								
8760,	cate be executed physician and the burial-transit	cal E		000 10 (01 00 0 00100	4331103 01).								
687	at at		d.										
Вох	eath certific attending p	W/	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of pregr		3-				2	3d. Date of deliv	rery	
_		ica	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet		Ectopic pre Other (spe					Month	Day ^	Year
P. 0	law requires that the de as been signed by the a 2 should be detached	Physician/Med	9 □ Unknown	9 Unknown									
	res tha igned I be det	by	Part II. Other significant conditions conf	ributing to death but not re	sulting in the u	nderlying car	use given i	n Part I.	23e. Di	tobacco u	se contribute to	the cause of d	eath?
Records,	w requir been si should								- 10	Yes 2x€	]No 3□Pro	bably 4 🗍	Jnknown
ec ec	e law r has be je 2 sh	Completed							24a. Wt	s an opsy	24b. Were aut	opsy findings ompletion of c	available
	ate pag	ပ္ပ							pe 1 ☐ Yes	formed?	death? 1 ☐ Yes		
Vital	Physician: Tribis certificaral director, p	Be	25. Was case referred to medical examiner?	ospital:					Death   Check only				
ot	hys this al dii	ို	1 ☐ Yes 2 ☑ No '"	1 Unpatient 2	28b. Time of		Oliter:	4 🗌 Nursing	g Home 5 □ Re	sidence 6	☐Other (Speci	Mospi	ice
UQ.	aling After fune	to	1   Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	M	ic. Injury at Work?	2 □ No	28d. Describ	a now injury	occurred		
Division of	teat tor:	fica	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome, farm, str				28f. Location	(Street and	Number or Rur	al Route Num	ber.
ă	- 9	Certification:	4 Homicide determined	building, etc. (Spec	ify)				City or 7	own, State)			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	dical (	29a Certifier Conting Physics (Check only one)	ician: To the best of my kin er: On the basis of examin and manner stated.	cwladge deal! ation and/or inv	vestigation, i	t the time in my opini	date and pla on, death or	acc and due to the	o cauca(s) o, date and	and manner as s place, and due t	stated. to the cause(s	:)
	omple	Med	29b. Signature and title of certifier	with the states.		29c.	License nu	ımber		29d. Date	signed (Month,	Day, Year)	
	40		I Chili eya	1 -18		(	d <b>424</b> 5	2			ember 7	-	
	V.		30. Name and address of persur who con		m 23a) (Type,	Print)							
			Chitra Rajagopal,	7			11 Ro	ad, Ro	ockville	, MD	20855		
1	Sta		31. Date filed (Month, Day, Year) DEC 0 8 200	32 Registrar's Sign	ature	elle)							
	Registr	ar	DEC 0 8 200	JOHNSON A	The same of the sa								

Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Tens 4b, c per doc 2851 1-9-06 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 12:35PM Ann Mary Alexander recember 22, 2005 /Medical 4b. City, Town, or Location of Death Rosedale 4c. County of Death Baltimore 4a. Fecility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye April 10, Square Frenklin CSDITG pedale 6. Sex 5. Social Security Number 7. Ade (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** ), 1934 Maryland 1 □ M 2 🛣 Months 71 Director 220-30-6122 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Middle River Director 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. 21220 8109 Maple Crest Drive or Itama 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced White "natural", Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Alexander, Ann permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lampard G. Lates Anna Mary Firmwale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2550 Robert Fulton Highway, Peach Bottom, Pa. 17563 George Kramer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Holly Hill Mem. Gard. Dec. 24, 2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Forest Survey Consee 22. Name and Address of Facility Bruzdzinski Funeral Home, p.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 eny l 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician intracranial /Medical Due to (or as a consequence of) Examiner Due to Iprias a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit be executed Due to (or as a consequence of): Box 68760. Physician/Medical The law requires that the death certificate ettending for use as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. <del>p</del> detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cete has t 24a. Was an autopsy performed? 1 ☐ Yes 2 NO Division of Vital To the Hospitel or Attending Physician: director 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 [Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident **Director**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Telefthying rhysicien: 10 the best of my knowedge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0056296 12-22-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Jasan Birnbaum Franklin Square Drive Battimore MD. 21237 31. Date filed (Month, Day, Year) State DEC 2 3 2005

DHMH 17 Rev 1/2001

Registrar

			- State Registrar	and / Department of Health ar Certificate of Death	Reg.	2005 1.11.05
-	Physic /Med	cal	1. Decedent's Name (First, Middle, Last)  ALFRED A. BARNES		Dec 3	Day Year 3. Time of Death 2 2005 112 So c.M
	Exami Funeral	ner	4511 005	rs. last birthday) If Under 1 Year If Under 24	CITY Hrs. 8. Date of Birth	4c. County of Death  N/A  9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	City, Town or Location	Min. (Month, Day, Ye 0 3 / 6 / 1	925 MARYLAND  10d. Inside City Limits
	he Mary 28e-f sh	Director	MD N/A	BALTIMORE CITY		1 X Yes 2 □ No
	3a or	I Dir	10e. Street and Number 566 SOUTH BEECHFIELD AVE	Inue 10f. Zip Code 21229		Citizen of What Country? USA
5-0036	72 hours after death with the Maryland natural", or Itama 23a or 28e-f show Alsal Exerchine must be redified at	by Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?			14. Race - American Indian, Black, White, etc.  Specify: BLACK
2	within 72 ho ene. than "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	f working 16b	b. Kind of Business/Industry
Maryland 21	s 1 and 2 should be filed within 72 hours If Health and Mental Hygiene. Itam 27 is marked other than "natural", other traumatic event, the Medical Exe	To Be Con	12TH 17. Father's Name (First, Middle, Last) ARTHUR BARNES	LAB TECHNICIAN  18. Mother's  MARY	Name (First, Middle, Maid TAYLOR	.S. ARMY den Sumame)
-5	s f and 2 shout Health and Nitam 27 is mail other traumail		19a. Informant's Name/Relationship (Type, Print)  SHARON HOLDER / DAUGHTER  20a. Method of Disposition	19b. Mailing Address (Street and Number of 7800 JODY KNOLL)  1. Place of Disposition (Name of	RD., WIND	ty or Town, State, Zip Code) 21244 SOR MILL, MD
Baltimore	permit. Pages Department of Important: ff it eny injury or o		117 Puriot 2 Comption 2 Demonstrates Chair	ARKISON FOREST 1.	2/28/05 O	WINGS MILLS, MD ERAL HOME 21207 E., BALTIMORE, MD
8760,	iste be executed hysician and hysician and the burial-transit	icai Examiner	23a. PA(1) Phi the disease, or complications that caused the desploys, or leart failure. List only one cause on each line.  Immediate cause (Finat disease) condition results in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consider that initiated events resulting in death) Last  Due to (or as a consider that initiated events resulting in death) Last  Due to (or as a consider that initiated events resulting in death) Last	equence of):  Later failure  equence of):  Exact failure		Approximate Interval Between Onset and Death Days  Months  Months
O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medicai	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	etal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not re	asulting in the underlying cause given in Part I.		o use contribute to the cause of death?
Vital Record	The law ate has b page 2 si	Completed			24a. Was an autopsy performed:	
Vit.	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No Hospital: 1 □ Unpatient 2 □	0.4	Death (Check only one)	
	ling After fune	-	27. Manner of Death 1 SA Natural 5 □ Pending 2 ○ Accident investigation 28a. Inte of Injury (Month, Day Year)	28b. Time of Injury at Work?  M 1 Yes 2 No	ng Home 5 ☐ Residenœ 28d. Describe how in	
Division	in the c	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office pify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To tha Hospital within 24 hours a To tha Funarel I completely filled	ledical	one) 2 medical Examiner: On the basis of examination and manner stated.	nowledge, death occurred at the time, date and pl nation and/or investigation, in my opinion, death o	lace, and due to the cause occurred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
•	To To con	Σ	29b. Signature and title of certifier  Fordi Mound.	29c. License number	-22 12	Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Ite	am 23a) (Type, Print)	ORE, MD	21220
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Sign	Pature former	0166, 111)	LIUT.

BARNES, ALFRED.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) DEC. 4:56A M **Physician** 21<sup>t</sup> 2005 RODNEY BEASLEY /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE CITY LOCHEARN FUTURECARE -Il Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 7 F Yrs. 54 05/04/1951 MISSOURI Director 489-58-2919 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "neturel", or itama 23s or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 X No BALTIMORE GWYNN OAK Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21244 USA 3808 MILFORD MILL ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK δ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) YEARS DISABLED 12TH DISABLED other 18 Mother's Name (First Middle Maiden Sumame) 17 Father's Name (First, Middle, Last) Be outd be f Pages 1 and 2 should be fment of Health and Mental Heart: if item 27 is marked of FREDDIE M. WILLIAMS BEASLEY NOAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 MILFORD MILL RD, GWYNN OAK, MD 21244 FREDDIE M.BEASLEY MOTHER or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If i any injury or once. KING MEMORIAL PK. 12/28/05 RANDALLSTOWN, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature & Pineral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Pant Enter the disease, or complications that caused the death shock, or reart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease) condition resulting in death) INH naunor **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Completed by Physician/Medical 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐yes 2☐No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has rebrovascular this certificate HISTORY Yes funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Inpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death 28b. Time of After 1 Natural 2 Accident s after de... 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2-21-50 1 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) HEIGHTS MC 185CM-17 NYNACOC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State noves.

DHMH 17 Rev 1/2001

Registrar

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Registrar

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					State of Maryla	and / Depa		f Health and M	Mental Hyg	_	41488
		ysicia		1. Decedent's Name (First, Middle, Last)  Agnes Louise Bo	artos				2. Date of Dea Month December	th	3. Time of Death 10:45 A M
		Medica amine	- 2	4a. Facility Name (If not institution, give si Oak Crest Care C	treet and number)		-	n, or Location of Death		4c. County of Dea Baltimo	th
	Fun Dire			5. Social Security Number 6. Sex		rs. last birthday) Yrs.		ear If Under 24 Hrs.	8. Date of Birth (Month, Day Dec. 18		thplace (State or Foreign buntry)
, 14		4		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
3/	Ith with the Marylar 23a or 28e-1 show	notified	rector	Maryland Harford  10e. Street and Number			Fores	st Hill		10g. Citizen of What Co	1 ☐ Yes 2 No ountry?
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4	036 ours after dea ral', or itsme	Examiner	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	Was Decedent Ever in Armed Forces?     □ Yes 2 No If Yes, Give Year or Dates:		Mas Decedent of Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	o Rican, etc.)	14. Race - Ame Black, Whit	
272	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thyeine.	he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		lent's Usual Oc kind of work do DO NOT use re Stered	cupation ine during most of wort tired) NUTS C	king	16b. Kind of Business. Health	Industry
BAR2	d be	<b>C</b>	To Be Co	17. Father's Name (First, Middle, Last)  Rodney H. Mart	in				Mae Mod	Maiden Sumame) SLEY	
CA	2 = 2			19a. Informant's Name/Relationship (Type Mrs. Lisa Goedeke				eel and Number or Ru. Dr Road, Fo		r, City or Town, State, I	
NE		or other		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ Re		D. Place of Dispo cemetery, cren Joseph				20c. Location - City or Baltimore,	
76,	Baltimore, permit. Pages 1 a Department of Hez Important: If itsm	eny injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License		22	. Name and Ad	dress of FacilitySch	imunek F	uneral Hom 2, MD 21236	es
	Physic / Med Exami	iner iner	Exam	23% art1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to (or as a cons	sequence of):		aying, such as cardiac		est,	Approximate Interval Between Onset and Death
	Division of Vital Records, P.O. Box 68760, Hospital or Attending Physicien: The law requires that the death certificate be executed to hours after death.  Funerel Director: After this certificate has been signed by the attending physician and	iched for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 [	Ectopic pregna Other (specify			23d. Date of de Month	ivery Day Year
	rds, P.O. I quires that the de n signed by the a	uld be deta	d by Pr	Part II. Other significant conditions cont	tributing to death but not r			•		bacco use contribute to	the cause of death?
	Division of Vital Records, or Attending Physicien: The law requires talter death.  Director: After this certificate has been signe	. page 2 should			brillat	ion				med? death? 2 1 Yes	itopsy findings available completion of cause of 2 No
	of Vital F Physicien: Th this certificate	direct	lo Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1  Inpatient 2	☐ ER/Outpatien	t 3□ DOA	Other	th <i>(Check only on</i> ome 5 ☐ Reside	ence 6 Other (Spe	cify)
	ion of nding Phy kh. :: After thi	e funeral	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work?	28d. Describe ho	ow injury occurred	
	Divisio  tel or Attendi s after death.	filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streecify)	eet, factory, offi	СӨ	28t. Location (St City or Town	treet and Number or Ru n, State)	iral Route Number,
	To the Hospital within 24 hours To the Funerel	=  .	edicai	29a. Certifier 1 Physical Examination (Check only one)	er: On the basi of my k ar: On the basis of exami and manner stated.	rnowledge, death ination and/or inv	onnumed at the restigation, in m	s time data and plane ny opinion, death occur	and due to the or red at the time, d	are and place, and due	to the cause(s)
4	To the within 2	dwoo		29b. Signature and title of certifier				ense number		9d. Date signed (Mont	
	-	/	1	30. Name and address of person who con	mpleted cause of death (II	tem 23a) (Type,	Print)	8646		Docemba	11) 12 200+
	r			Anna Monics	8800 L	uc. Ithe	5 BOU	(evara)	Park	الم وال	112 515 34
	Re	State gistra	_	31. Date filed (Month, Par Year) 3	2005 32. Registrar's Sig	1 15	COLL				

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Supplement   Sup				·				Months Days	Hours	Min. No	Month, Day, 1	1917	Mary Land
17   Pather's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Mailing Address (Strees and Number City or Town, State Zip Code)   14.09 Lake Vista Drive, Joppa, Md. 21085   14.09 Lake Vista Drive, Joppa, Md. 21085   15.00 Location Silver (Specify)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or				Usual Residence of Decedent									
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17   Pather's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Mailing Address (Strees and Number City or Town, State Zip Code)   14.09 Lake Vista Drive, Joppa, Md. 21085   14.09 Lake Vista Drive, Joppa, Md. 21085   15.00 Location Silver (Specify)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or		ems ems	ne	11. Marital Status			S. 13.	Was Decedent of H	fispanic Ori an, Mexican	igin? (Specify n, Puerto Rica	Yes or No- .n, etc.)		
17   Pather's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Mailing Address (Strees and Number City or Town, State Zip Code)   14.09 Lake Vista Drive, Joppa, Md. 21085   14.09 Lake Vista Drive, Joppa, Md. 21085   15.00 Location Silver (Specify)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or	9	or It	Y.F.		If Yes, Give	No	1						
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17   Pather's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Mailing Address (Strees and Number City or Town, State Zip Code)   14.09 Lake Vista Drive, Joppa, Md. 21085   14.09 Lake Vista Drive, Joppa, Md. 21085   15.00 Location Silver (Specify)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State Zip Code)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or Town, State)   15. Mailing Address (Strees and Number City or	12	withir sne. than	ם		College (1-4or	5+)			<i>b)</i>			own h	ome
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Joann Riemer/daughter    1409 Lake Vista Drive, Joppa, Md. 21085	an	d be ontal	Be		,								,
Joann Riemer/daughter    1409 Lake Vista Drive, Joppa, Md. 21085	7	should Me mark mati	ř		p (Type, Print)		19b. Mailir	na Address (Street		<del>-</del>		City or Town. S	State. Zip Code)
20. Method of Disposition (Name of Commercy of Commerc	Ma	id 2 s ith ar 27 is treu											
Physician / Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause or each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause or death?  25a. Part. Enter the disease, or conditions and cause of death?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25c. If yes, cutcome of pregnancy; the past 12 prontine?  25b. Was cause referred to medical examiner?  25c. In yes, cutcome		1 an Hea tem 3				20b. P	lace of Dispo	sition (Name of	1	Date	20	Oc. Location - C	City or Town, State
Physician / Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause or each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause or death?  25a. Part. Enter the disease, or conditions and cause of death?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25c. If yes, cutcome of pregnancy; the past 12 prontine?  25b. Was cause referred to medical examiner?  25c. In yes, cutcome	10	ages ont of t: If i		Puriol 2 Committee 2 Permanal from State cemetery, crematory or other place)									imore. Md.
Physician / Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause on each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause or each line.  25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal serves and obath shock, or heart failure. List only one cause or death?  25a. Part. Enter the disease, or conditions and cause of death?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25b. Was desendent pregnant; the past 12 prontine?  25c. If yes, cutcome of pregnancy; the past 12 prontine?  25b. Was cause referred to medical examiner?  25c. In yes, cutcome	₽	nit. Pa artme orteni Injury				1101							
Physician Madical Examiner  Ph	Ba	Dep Impo		) SUIT									
Physician / Medical Examiner    Total Control of Physician / Medical Examiner				23a. Part1. Enter the disease, or o	omplications that cause	d the death							Approximate
Medical Examiner    Medical Examiner   Medical Exam		<b>5</b>			1			7	1.		-		anset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underl				disease or condition	_ a			Dymin,	114		<del>-</del>		3 years
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The standing of the standing o			ē	if any leading to immediate	b Due to (or as	a consequ	uence of):					10.	
The standing of the standing o	V	uted d ansit	m	Cause (Disease or injury	V .								
The standard of the standard o	ć	exector and and ital-tr	Exa	resulting in death) Last		a consequ	uence of):						
25. Was case referred to medical examiner? No Display on the state of	9/	ysicia ysicia	cal	,	d								
25. Was case referred to medical examiner? No Display on the state of	9	tificat ig phy as th											
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25. Was case referred to medical examiner? No Display on the state of	Ö.	of the by the tache	hys	9 Unknown	9LI UNKNOWN								
25. Was case referred to medical examiner? No Display on the state of		as the		Part II. Other significant condition	s contributing to death t	but not rest	ulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	icco use contrib	oute to the cause of death?
25. Was case referred to medical examiner? No Display on the state of	ğ	en sig	ed								1 🗌 Yes	2 No 3	B Probably 4 Unknown
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25. Was case referred to medical examiner?  1	B	The I	mo								performe	ed? de	ath?
The state of the s	ita	ien: rtifica stor, I	a	25. Was case referred to medical					26. Place				
Signatural solutions of the state of the sta	<b>†</b>	S S			Hospital: 1  Inpati	ent 2	ER/Outpatien	t 3 DOA Oth	iθГ: 4 Nu	ırsing Home	5 🗌 Residen	ce 6 Other	(Specify)
Property of the control of the contr	0	ng Pł fter tł neral			28a. Date of Inju (Month, Da	ury ay Year)		28c. Injur Wor	y at k?	28d.	Describe how	injury occurre	d
State Registrar  281. Location (Street and Number or Rural Route Number, farm, street, factory, office  282. Location (Street and Number or Rural Route Number, City or Town, State)  283. Suicide 4 Homicide 284. Location (Street and Number or Rural Route Number, City or Town, State)  285. Location (Street and Number or Rural Route Number, City or Town, State)  286. Place of Injury - At home, farm, street, factory, office 287. Location (Street and Number or Rural Route Number, City or Town, State)  288. Place of Injury - At home, farm, street, factory, office 289. Location (Street and Number or Rural Route Number, City or Town, State)  289a. Certifier (Check only one)  299b. Signature and title of certifier  299b. Signature and title of certifier  299b. Signature and title of certifier  299b. Signature and title of certifier  290b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  290b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  290b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  290c. License number  290c. License number  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)  290d. Date signed (Month, Day, Year)	<u>Ö</u>	endii sath. or: Ai he fu	atle	2 Accident investiga				M 1 🗆	Yes 2	No			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date filled (Month, Day, Year)  32. Aegistrar's Signature  32. Aegistrar's Signature	Ξ	ter de irect	ŢĮ.	determin	280. Place of In	iury - At ho tc. (Specify	me, farm, str /)	eet, factory, office		28f. l	Location (Stre City or Town,	et and Number State)	r or Rural Route Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature		itel o											
and manner stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  December 19, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date filed (Month, Day, Year)  DEC 2 3 2005  32. Registrar's Signature		Hosp 4 hot Fune ely fii	ical	(Check only 2 Medical E	Physician: To the best caminer: On the basis of	of my kno of examinat	wledge, death tion and/or in	n occurred at the tire vestigation, in my o	ne, date an pinion, dea	nd place, and on th occurred at	due to the cau t the time, dat	ise(s) and mani e and place, an	ner as stated.  Ind due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  DEC 2 3 2005  32. Registrar's Signature		the the I	Med	one)	and manner st	tated.		20c Linear	e number		20	1 Date signed	(Month Day Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  DEC 2 3 2005  32. Registrar's Signature		To wit	-	250, Signature and title of centrer	- 100			250. LICENS	y/Ax	-2	7	. Date signed	(wonus, pay, rear)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Scott Huswill 2 North Avinus Bel Air Manyland 2/0/19  State Registrar  31. Date filed (Month, Day, Year)  DEC 2 3 2005  32. Registrar's Signature	,			7 / 11	1111			<i>y</i>	5/03		U.	cembe	v 19, 2005
State Registrar DEC 2 3 2005 32 Registrar's Signature	_	<b>b</b>		C. 11 11.	no completed cause of a	Nor	23a) (Type,	Print) 1641	B11.	Ain N	Duryla	and a	21014
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			For State Registrar	State o	of Marylai		artment of F tificate of		nd Men		iene () ()	5		90
	Physici		1. Decedent's Name (First, Middle Margaret May I			-			1 1	Date of Deat Month ec. 21		Year	3. Time of 8:30	Death P M
	/Medio Examir		4a. Facility Name (If not institution Joseph Ritchie		ımber)		4b. City, Town, o		Death		4c. County o	of Death		
	Funeral Director	77	5. Social Security Number 220-14-8896	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs 80		If Under 1 Year Months Days	If Under 24	Hrs. 8. E	Date of Birth Month, Day, Ct. 22		9. Birthp Coun Mar	lace (State o try) yland	r Foreign
,	the Maryland 28a-1 ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A			ity, Town or Lo						1	0d. Inside Ci	
	th with the 23a or 28	al Direc	10e. Street and Number 400 Millington	Ave.			10f. Zip Code 21223			1	0g. Citizen of W	hat Coun		
C	er dea	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	Armed Fo	2 Ø∏ No ive		Was Decedent of F f Yes, specify Cuba 1 ☐ Yes 2X No		n? (Specify Puerto Rica	Yes or No- n, etc.)	Black	Americ White,		
1	Maryland ZIZI5-UU30 tid 2 should be filed within 72 hours aft th and Mantal Hyglene. 27 is marked other than *natural; or traumatic event, tre Medical Exami	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (		16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired aker	pation during most o d)	í working		16b. Kind of Bus		dustry	
	land Z I Z Id be filed within ental Hygiene. ked other than ic event, tram	To Be Co	17. Father's Name (First, Middle, Frank Krauss	Last)					Name (Fir		Maiden Sumame			
	re, Maryland stand 2 should be t Health and Mental b Item 27 is marked of other traumatic eve	-	19a. Informant's Name/Relations Nancy Hubbard	nip <i>(Type, Print)</i> , daughte	er		ng Address (Street Hill Top	and Number	or Rural Ro			State, Zip 1226	Code)	
10			20a. Method of Disposition  1 💢 Burial 2 Cremation  4 Donation 5 DOther (S)		State G16	Place of Dispo cemetery, crer on Have	sition (Name of natory or other place n Cemeter	ry 12	Date 2-24-0		20c. Location - 0 Glen Bu:			
3/21/05 82	It be executed the beautiful transit t	fedical Examiner	21. Signature - Fryn ral Service  23a rart - Enter the disease, rancok, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	1 15th	th. Do not ent uence of): quence of):	mbTb35e <sup>Ad</sup> ff 328 Su1ph er the mode of dyin	nur Spr	ing R	d. Arl	butue, P	MD.	21227 Approximate Interval Beh Onset and D	ween 🧳 👔
> <	The Cords, F.O. BOX 58 The law requires that the death certifical tie has been signed by the ettending phy agge 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregn birth 2 Fet nant at time of lown	at death 3	Ectopic pregnancy Other (specify)	/			23d. Date Mon		,	ear .
3	cords, r requires that been signed b	þ	Part II. Other significant condition	ns contributing to d	leath but not re	sulting in the u	nderlying cause giv	ren in Part I.			pacco use contri	bute to th		eath? Inknown
		Completed								24a. Was ar autops perform 1 Yes 2	y pr ned? de		osy findings and pletion of ca	
0 7	LIVISION OF VICAL TO the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification: To Be	25. Was case reterred to medical examiner?  1  Yes 2 No  27. Many of Death 1  Natural 5 Pendin investig 2  Accident 3 Suicide 4 Homicide 6 Could determ	ation  t be ned 28e. Place build	of Injury tth, Day Year) e of Injury - At h ling, etc. (Special	<i>fy)</i> owledge, deatl	28c. Injur Wor M 1 □	y at k? Yes 2 □ No	28d. 28f. L	Describe ho  Location (Str. City or Town	once 6 Jothe ow injury occurred and Number of State)	or or Rura.	ated.	
8	2	Medical	(Check only 2 Medical one)  29b. Signature and title of certifies	Examiner: On the b	pasis of examination of stated.	ation and/or in	vestigation, in my o	pinion, death	occurred at	t the time, da	ate and place, and pla	nd due to	the cause(s	
	Sta Registi		31. Date filed (Month, Pay, Year)	431	se of de th (ite	erub		Fit!	HM	me,	Mil	2	12/5	,

			1- For State of Maryland / Department of Health Certificate of Dear	th and M ath	ental H	ygier Reg. N		41491
	Physi	cian	1. Decedent's Name (First, Middle, Last)		2. Date of D	Death		3. Time of Death
Ы	/Med	ical	Richard S. Berarding		Decembe		Pay Yea 5, 2005	4:40 a M
4	Exam	iner	Journal Parsianal Haustine	ion of Death			c. County of De	
	Funera			ider 24 Hrs.			ince Geo	
	Directo		021-34-6508 1 M 2 F 59 Yrs. Months Days Hour		8. Date of B (Month, D	Day, Yea	Mac	Birthplace <i>(St</i> ate or Foreign Country) Sachusetts
	ס •		Usual Residence of Decedent		April	15, 1	1946	odendse ces
	laryta shov	5	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	the M	ecto	Maryland Laurel					1 ☐ Yes 2 ☐ No
	with be or	급	10e. Street and Number 10f. Zip Code 13605 Avebury Drive #32 20708			10g. C	itizen of What	Country?
	death ms 23	Funeral Director	13.600 AVEDURY Drive #32 20708  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic (	0-1-1-0 (0	"	U.S.A.		
9	72 hours after death with the Maryland natural', or Items 23e or 28a-1 show Itsal Exart fractional be Livitified at			ican, Puerto A	iry Yes or N ican, etc.)	0-	14. Race - An Black, Wh	nerican Indian, nite, etc.
Maryland 21215-0036	ural',	d by	Year or Dates:	city:			Specify: W	nite
5-(	72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during m	nost of working	7	16b. I	Kind of Busines	s/Industry
12	within ene. then "	m d	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	nost of working	•			
9	filed within the state of the state	e Co	17 Esthor's Name (Circle Middle 14)				ral Gover	nment
an	s 1 and 2 should be filed within 72 h if Health and Mental Hygiene. Item 27 Is marked other then "natu other treumatic event, In. Medical	To B	Francis Barrell	other's Name (		e, Maidei	n Sumame)	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num	rence Doy	le Pouto Numb	or City	as Taura Chair	7: 0 11
	and 2		Robert Berardino/Son 212 Hollins Lane Arno			2101		ZIP Code)
ore	of He fiter roth		20a. Method of Disposition 20b. Place of Disposition (Name of	Da			ocation - City o	r Town, State
Ĕ	Pag ment ant: I ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Woodlawn Cemetery	12/21/2	005	Ever	ett. Mass	achusetts
Baltimore,	permit. Pages 1 and 2 should be fil Department of Health and Mentat H Important: If item 27 Is marked out any injury or othar treumattic even QDEs.		21. Signature of Funeral Service Licensee 22. Name and Address of Fac Fleck Funeral Home	cility				
	# D = 6 0		1 / Vim 2 // Whi 7601 Sandy Spring	Road L	aurel	Mary	land 2070	7
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or i	espiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Acute Myocardial Infarction					Onset and Death
В	Examiner		Due to (or as a consequence of):					
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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Ó,	e exe ian ar urial-t		resulting in death) Last Due to (or as a consequence of):					
68760,	ficata be executed physician and is the burial-transit	edicai						
	- 03	Mec	IF FEMALE:					
Вох	eath certif attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy				23d. Date of de	,
0	at the de by the i	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				Month	Day Year
Ф	g g		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part	+ 1	23e Did to	phages u	IOO opposituate to	the cause of death?
of Vital Records,	w requires been sign should be					es 2[	_	obably 4 Unknown
000	law re	piet			24a. Was a			
Ä	0 - 0	Completed			autop		prior to death?	itopsy findings available completion of cause of
ita	ysicien: Th		25. Was case referred to medical examiner? 26. Place	ce of Death (C	1 Yes		1 ☐ Yes	2 🗆 No
Ž	d is	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 No ER/Outpatient 3 ☐ DOA Other: 4 ☐ No				S ☐Other (Spec	264
no		ou:	27. Manner of Death 1		. Describe h			ony)
Sic	Attending r death.	cat	2 Accident investigation M 1 Yes 2	]No				
Division	lor A after Direction by	Certification;	4 Homicide  determined  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (S City or Town	treet and n, State)	<i>Number</i> or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely fillad in by		29a. Certifier 1/X Certifying Physician: To the best of my knowledge death as a second of the control of the co					
	ne Ho ne Fu sletely	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date an  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea  and manner stated.	ind place, and eath occurred a	due to the c it the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the To the Comp		29b. Signature and title of certifier 29c. License number		2	9d. Date	signed (Month	Dav. Year)
,			Willent / / duly in D120	716	-		uber 1	
	25		30. Name and address of person who collipled cause of death (Item 23a) (Type, Print)	,		لعب	- PG( /	11 dus
	<i>F</i>		31 Date filed (Month Day Year) 32 Projectorio Singary	20707				
	Sta Registra	~	31. Date filed (Month, Day, Year) DEC 2 3 2005					

JOANNE BACKHAUS 05-08598 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.PII.27, perME.0851.1/25/06 II

1- State of Maryland Department of Health and Mental Hygierre Office Registrar Programment of Death

1- Registrar RKD 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** BACKHAUS JOANNE 20, DECEMBER 2005 9:43A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ROSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 🖾 F 43 220-90-9738 Yrs July 27, 1962 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heatih and Mental Hygiene. Importent: If item 27 is marked other then "netural; or items 23a or 28e-1 ehoveny injury or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No BAltimore PERRY Directo MANY/AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U-5-A 3 MILL 21236 LAR Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NEVER WORKED IZ WERKED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BACKHAUS hARlo H 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BACKHAYS 8162 Glen ARBOR DRIVE BAHIMONE, MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD Cenetery Dec 23, 2005 BALTIMORE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLUCRAL HOLLE C.H.T. STCLLA ITARtley MILLER-BAlto- MD KOAD all 7527 HARFURD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute bronchopneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner sicien and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death P.O. I 9 Unknown 9\ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Narcotic use, lupus, cardiomegaly page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

NZYes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 Ĭ DOA 28a. Date of Injury Fnd 28b. Time of Fnd (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 9700 5 Pending investigation efter death. 12/20/05 1 ☐ Yes 🛣 No unk 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8322 Popular Mills 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide found at home Nottingham, MD within 24 hours e To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 21, 2005 O.C.M.E. Duchs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Tasha Z 31. Date filed (Month, Day, Year) DEC 2 3 2005

2. Hegistrar's Signature

Greenberg

M.D

111 PENN STREET BALTIMORE MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** DEC 19 2005 ELIJAH BRIAN BERRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA FNTER

7. Age (In yrs. last birthday)
Yrs.

H Under 1 Year

H Under 24 Hrs.
Age (In yrs. last birthday)
Yrs.

H Under 1 Year

H Under 24 Hrs.
Age (Month, Day, Year)
Peccember 15, 2005

Maryland Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F Director Usual Besidence of Decedent 10d. fnside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 No 2 No Director Washington None 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1511 Carswell Circle, S.W., Apt. G 230 20032 United States Funeral Pages 1 and 2 should be filed within 72 hours after death vient of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy Jason Berry Cristina Lyn King ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 to other tre Guy Jason Berry / Father 1511 Carswell Circle, S.W., Apt. G, Washington, D.C. 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 23, permit. Pages Department of Important; if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Memorial Park 2005 Sparta, Tennessee 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Angelet Dune M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LIVER TUMOR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? page 1 X Yes 2 💢 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ၉ 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 101057905 (VA) 21/05 MD NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 LCDR MC USN EDWIN C. DOE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Physic	ian	1 - State Registramend Item #7  1. Decedent's Name (First, Middle, Last,					Date of Death     Month	Day Yea			
/Medi			UBLITZ	<u> </u>	41. Oh. T.	and another of Donath	DECEMBER	4c. County of De			
Exami	ner	4a. Facility Name (If not institution, give HARBOR HO			•	or Location of Death		N/A	eath		
Funeral	*** F	5. Social Security Number 6. Second		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.			hirthplace (State or Fore		
Director		210 30 9493	M 2□F 60	6 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	1939 м	aryland		
and W		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Lim		
Mary.	ţō	Maryland N/A		Baltimo	re				1 2 Yes 2 □ N		
within 72 hours affer death with the maryland ene. Then "netural" or frems 23e or 28e-f show the Madical Examinar matal be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?		
23a	ral	3560 Horton Ave				225		U.S.			
items items	nne	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.		
l'or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	1	☐ Yes 2🖾 No	Specify:		Specity: W	hite		
2 llox	Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	lent's Usual Occu	pation during most of work	ing 16	b. Kind of Busines	ss/Industry		
19. 19. 19. 19. 19. 19. 19. 19. 19. 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	Weld	OO NOT use retire	d)		[a] a d	D 11		
Hygier Hygier ther th		9th 17. Father's Name (First, Middle, Last)		werd	.eı	18 Mother's Nam	e (First, Middle, Ma	laryland	ргуаоск		
ontal h	Be C		es LeRoy Bar	ublitz. S	r.		thy Beatr		ford		
and Menti is marked is marked	오	19a. Informant's Name/Relationship (Ty				and Number or Rur					
alth a 27 is		Charlotte Baubli	zz / wife	3560	Horton A	venue B	altimore,	Marylan	d 21225		
of He of He fitam roth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ F	emoval from State	Ob. Place of Dispos cemetery, crem	sition (Name of natory or other pla	ce)		c. Location - City of			
ment ment ient: f		4 ☐ Donation 5 ☐ Other (Specify)		Bayview (	•	,			, Maryland		
permit. Pages 1 and 2 should be lied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Indonethat if Itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. I'm Medical Examinat mant be notified at once.		21. Signature of Funeral Service Licens	emuouy	ho 41	Name and Addre	ess of Facility Go hie Highwa	once Fune ay Balti	ral Servi more, Mai	ice, P.A. ryland 2122		
hysician Medical xaminer perial-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):	LONG	- CANC	**K		4 MONT		
	Physician/Medi	IF FEMALE:	3c. If yes, outcome of pr 1 □Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of d Month	elivery Day Year		
ned b e deta	by Pi	Part II. Other significant conditions con	_	*		ven in Part I.	23e. Did tobac	co use contribute	to the cause of death?		
w require been sig should b	ed b	CONGESTIVE	HEAR	T FAI	LURE		1 <b>X</b> (Yes	2 □ No 3 □ I	Probably 4 Unknow		
been	Completed	CORONARY	ARTERY	DIZE	ASE		24a. Was an autopsy performe	prior to d? death?	autopsy findings availat completion of cause of		
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to the hospitel of Attending Frifysician: The law within 24 buys after death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s	edical Certification; T	2 Accident 3 Suicide 4 Homicide  22 Cariffur (Check only one) 29b. Signature and title of certifier	building, etc. (S) sician: To the best of my ner: On the basis of exa and manner stated.	pecify) y knowladgo, death	accurred at the trestigation, in my case 29c. License	opinion, death occur	and due to the cause ed at the time, date	and place, and du	nth, Day, Year)		
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per ft 9850 12-23-05 vt
State of Maryland / Department of Health and Mental Hygiege 0 5 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 136AM **Physician** DECEMBER 13 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RAMOALZSTOWN BALTIMORE NTOTHWEST HOSPITAL TEN LEN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months X M 2□F 75 Yrs. Director 218-28-0290 Aug 18 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XXYes 2□No <u>ĕ</u>Mary1and Anne Arundel Annapolis 4 contact of the second sec Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1607 Orchard Beach Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: ģ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gilbert Brashears Sr. Maude Hebron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maude Byrd(Sister) 3327 Kerry Rd. Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 27 27 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Maryland Veteran 12<del>-19-</del>05 Crownsville, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. B. Hoese MODY8 821 West St. Annapolis, Md. 21401 Larry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCIERDIC CARDIDVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 D No 2 No 1 🗌 Yes 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2No P 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUAD, RATIOALLSTO 54V) 020 CLIFF FAGERIMO LOVO-5

DHMH 17 Rev 1/2001

State

Registrar

with the Maryland

death

item 27 is marked other than "natural", or iteme 23a or 28a-f ahow other traumatic event, the Modical Examinar must be notified at

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31. Date filed (Month, Day, Year)

DEC 2 3 2005

After

24 hours after death.

within 2 To the

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

To the Hospital or Attending Physician:

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

32 Registrar's Signature

			1 - For State Registrar	State of M	arylan		artmeni rtificate			and M	-	gien	11115	41496
9	, k. 2		Decedent's Name (First, Middle, Last)								2. Date of De	ath		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location o	f Death		40	. County of Deat	h
	- A 54	<u></u>	Union Memorial Hos					timo						
	Funeral		5. Social Security Number 6. Sex 722–05–5310	7. Aq M 2□F	ge (In yrs. 1 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under:	Min.	8. Date of Bir (Month, Da Dec. 2	th ly, Year	9. Birt	hplace (State or Foreign juntry) Virginia
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	or 28	Funeral Director	10e. Street and Number				10f. Zip				ĺ	-	itizen of What Co	ountry?
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920	urs af	Ď	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:	WW	VII	1 □ Yes 🎗	No No	Specify:				Specify: Wh	nite
21215-0036	within 72 hours after death with the Maryland ane. Itan "natural", or iteme 23a or 23e-f ehow ha Madical Examinar must te motified at	Completed	15. Decedent's Educ (Specify only highest grade	ation		16a. Dece	kind of wor	k done d	urina mosi	of work	na	16b. F	Kind of Business/	Industry
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Maryland	Mental Merked o	To Be	Albert E. Crites								C. Sny		,	
ary	should ind Men marke	F	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	i Route Numbe	er, City	or Town, State, 2	Zip Code)
	and 2 alth a 127 le		Stanley R. Crites (	Son)		6902	Birdv	vood	Aven	ue,	Baltimo	re,	Marylar	nd 21220
Ore	of He of He fittern roth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	C	lace of Dispo emetery, crer	natory`or o	her place			Date		ocation - City or	
Ë	Pages ment of ant: If It		4 □ Donation 5 □ Other (Specify)		Hol	_								Maryland
Baltimore,	permit. Deporte Importe any nj	10a. State   10b. County   10c. City, Town or Location   10b. County   10d. State   10b. County   10d. State   10d. Zip Code   10d. Citizen of What County   10d. Street and Number   329 Magnolia Terrace   21221   U.S.A.   11. Marital Status   1. Marital Status   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Married 2   Marined   1. Marital Status   1. Mare Decedent Ever in U.S.   1. Mare Decedent Mark County (Cuban, Mexican, Puerio Rican, etc.)   1. Mare Marital Status   1. Marital Status   1. Mare Marital Status   1. Mare Marital Status   1. Mare Marital Status   1. Marital Status   1											land 21221	
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89 )	artifica ing ph e as t	Med	fF FEMALE:											
Вох	leath certificate b attending physic	lan/	23b. Was decedent pregnant in the past 12 months?	ic. ff yes, outcome	2 Fetal	fdéath 3□	Ectopic pr						23d. Date of del Month	ivery Day Year
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P.0	that t	y Ph	Part fl. Other significant conditions con	tributing to death t	out not resi	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
Records,	quires n sign uld be	d by	Diabetes Melli	istype	2,	Coron	erry	ant	ery		1 🗆 '	Yes 2	. No 3 Pr	obably 4 Dinknown
00	s been si	piete	Disease, Rena	1 1250	FF: 6	ienc	ч.'				24a. Was		24b. Were au	topsy findings available
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ita	ysician: us certifica director, j	Bec	25. Was case referred to medical examiner?							of Death	(Check only o			
of Vital	Physical this call dire	၉	1 ☐ Yes 2 ☑ No	ospitaf. 1 Inpati		ER/Outpatier			4 🗆 190				6 ☐Other (Spec	cify)
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Div	effer Dire d in b	Certification:	4 Homicide determined	28e. Place of In building, e	tc."(Specify	y)	,				City or Tox			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred											stated. to the cause(s)			
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	10+1		30. Name and address of person who co				Print)							
	1		Stephen Nguyen		201		Un	iners	ity t	arki	nay, B	4	timor	e, MD21218
- 10 mg	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rars Signa	ture	* K	,	-					
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		For State Registrar	State of M		/ Depa		of H	ealth ar		ntal Hy		05	41497	
Physici /Medid Examir	cal	1. Decedent's Name (First, Middle, I NADGE  4a. Facility Name (If not institution, g  Har-725 CV)	ive street and number		1-12 1-2-1-1-1	Co	Cyr	Location of E	Death	Date of De Month	Day 21 4c. Co	Year 2 Year unity of Death	3. Time of Death  5. 3 c ()M	
Funeral Director		5. Social Security Number 579-38-7087  Usual Residence of Decedent		Nge (In yrs. las 34	st birthday) Yrs.	If Under Months		If Under 24 Hours	Min.	Date of Bir (Month, Da Jan 7	th ly, Year) 1921	9. Birth Cou Eng	place (State or Foreigr ntry) Land	
h the Maryland r 28a-f show	irector	10a. State 10b. County 10b. County 10c. Street and Number			Town or Lo enelg		Code				10g. Citizen	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ∑ No	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	3213 Rosway Cour  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceden	6? ₹No	1				? (Speci Puerto Ri	fy Yes or No can, etc.)		Race - Ameri Black, White, ecity: wh:	etc.	
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e, Mar 1 and 2 sho Health and lam 27 is m		19a. Informant's Name/Relationship Pamela Kirby (da  20a. Method of Disposition		20h Plac	19b. Mailir 3213 ce of Dispo	Roswa	у Сс	ourt, (	or Rural F Glene Dat	elg, M	ld 2173	own, State, Zij 37 ion - City or T		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		1 □ Burial 2 ☒ Cremation 3 1 □ Burial 2 ☒ Cremation 3 1 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	erify) ensee	All	Count	y Cre Name and	mati Addres	on 12-	-23-0 Haigl	05 ht Fun	Sykes eral H	ville,		
Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Under into Cause (Disease or injury that initiated events resulting in death) Last	mplications that causity one cause on each a.  Due to (or a b. Due to (or a c. Chrs.)  Due to (or a Due to (o	s a consequent of the conseque	Do not ent  To No  noe of):  FRET E  noe of):  ST. Co	er the mode	of dying	, such as ca	rdiac or r		rrest,		Approximate Interval Between Onset and Death	
Box 687 ath certificate ttending phy.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 23c. If yes, outcom 1	2 Fetal de	eath 3	Ectopic pre					23d.	Date of deliv Month	ery Day Year	
rds, P.O. I quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions	contributing to death	but not resulti	ing in the ur	nderlying ca	ause give	n in Part I.			obacco use d		he cause of death?	
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DIVI To the Hospital or At within 24 hours after of To the Funeral Direct Completely filled in by	Medical	(Check only one) 2 Medical Ex.	ATTEX.3	of examination stated.	n and/or inv	restigation,	in my opi	nion, death	occurred	at the time,	date and pla	manner as sce, and due to gned (Month,	the cause(s)	
d		30. Name and address of person who	omes I	death (Item 2	3 00	Print) ・カムハの	"7	יטוצב	8	wite 3	H 3	167.001	(170)	
Sta Registi		31. Date filed (Month, Day, Year)	2005	and digitally	Con	and a								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 18 per fh 9850 12-23-05 vt. State of Maryland 7 Department of Health and Mental Hygiege 05

Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DEC. **Physician** 22, ELNORA MARIE DAVIS 2005 9:50A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9654 ASHMEDE DRIVE ELLICOTT CITY HOWARD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs. 382-24-0137 Director 92 02/14/1913 TEXAS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itema 23a or 28e-f show the Medical Examiner must be notified at MD HOWARD ELLICOTT CITY 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9654 ASHMEDE DRIVE 21042 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER 12TH DOMESTIC rages 1 and 2 should be file tment of Health and Mental Hyc. sht: if Item 27 is mark-ry or oth-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BOYD ZACK BOYD ELLEN BOTD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 MD 9654 ASHMEDE DRIVE, ELLICOTT CITY, JAMES DAVIS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. MD NATL MEM PARK 12/29/05 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MARYLAND 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Uneral Servica Licensee The the dease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, or not enter the mode of dying, such as cardiac or respiratory arrest, or near failure. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Approximate Interval Between Onset and Death iate Cause (Final e of condition ng in death) Coronary Artery Disease Physician 30 years /Medical Due to (or as a consequence of): **Examiner** Hypertension 50 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and is the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 No 3 ☐ Probebly 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerei 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Daarwa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0 Rita Pabla, 13621 Baltimore Ave., Laurel, MD 20707 M.D., 32. Digistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 - For State Registrar	State of Marylan		ment of H		Mental Hy	giene Reg. No. 005	41499
	Physici /Medi	cal	Decedent's Name (First, Middle, Last, James Joseph Da     4a. Facility Name (If not institution, give	avis, Sr.	Alt	City Town or	Location of Deatl	2. Date of De Month	Day Yea  Mbck / (e i 20)  4c. County of De	15 343 pm
	Examir Funeral Director	ier	Maryland Grene 5. Social Security Number 6. Sei	ral Hospit	al £	Under 1 Year onths Days	ORC ( If Under 24 Hrs. Hours Min.	THY	N/A	irthplace (State or Foreign Country) ryland
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		y, Town or Location					10d. Inside City Limits
	th with the 23s or 28s	al Directo	10e. Street and Number 510 W. Frankli	n Street	1	Of. Zip Code 21201			10g. Citizen of What USA	Country?
9036	72 hours after death with the Maryland 'natural', or iteme 23a or 28a-f ehow dical Examiner must be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U. Armed Forces? 1. ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	If Ye	Decedent of His is, specify Cubar Yes XXNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race · Ar Bfack, Wi B Specify: 1 a	nerican Indian, nite, etc. , CK
Maryland 21215-0036	f within jiene. r than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e completed) Colfege (1-4or 5+)	16a. Decedent (Give kind life. DO) Superv	visor	uring most of wor		and Recre	e City Park
/land	be d la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last)  James Henry Da	vis, Sr.			18. Mother's Nan Lucy W		, Maiden Sumame)	
, Mar	s 1 and 2 should f Health and Mer item 27 is marks othar traumatic		19a. Informant's Name/Relationship (Ty James J. Davis,		19b. Mailing A 2909 I	ddress <i>(Street</i> a. Presstn	nd Number or Ru nan St.	Balti	er, City or Town, State More, Mar	$v_{\rm land}^{Zip\ Code)}$ 21216
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	lace of Dispositio emetery, cremato eenmour		tery 1	Date 2/21/0	20c. Location - City of 5 Baltimo	or Town, State ore, Marylan
Balt	permit. Page Department Important: If any injury o		21. Signature of Foneral Service Pers	(iis	524	40 Reis	stersto	wn Rd	Baltimore	neral Home e,Md 21215
	Physician	_	23a. Pand. Enter the disease, or complement, or heaft failure. List only or immediate Cause (Final disease or condition	ications that caused the death ne cause on each line.	-A 1	se mode of dying $S + a S$		or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed  manual death certificate be executed  e attending physician and ad for use as the burial-fransit	ledicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	uence of); 3 Ce// uence of);		ino-ma	of L	'ung	2 years
P.O. Box 6	that the death certific hed by the attending p detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	I death 3 □ Ect	opic pregnancy ner (specify)			23d. Date of d Month	efivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con		ulting in the under	lying cause giver	n in Part I.	112		to the cause of death? Probably 4 □Unknown
tal Rec	The ate h page	e Completed	25. Was case referred to medical				26 Phase of Das	1 ☐ Yes	prior to death?	
Division of Vital Records,	Phys this aldi	To B	examiner?	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other	4 LI Nursing H	ome 5 Resi	dence 6 □Other (Sp how injury occurred	ecify)
Divis	Dit te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street,	factory, office	-	28f. Location (: City or Tou	Street and Number or I wn, State)	Rural Route Number,
	the Hospital in 24 hours a the Funeral C	edical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death occition and/or investi	curred at the time gation, in my opi	e, date and place nion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. le to the cause(s)
)	To the within 2 To the complet	W	29b. Signature and inter of certifier	auga ) w		29c. License	number 3 3 8 6		29d. Date signed (Mor	
	3		30. Name and address of person who co	,	23a) (Type, Print Eatuv			more	IND. 21	
	Sta Registr	-	31. Date filed (Month, Day, Year) DEC 2. 3. 20	32. Registrar's Signa						

			1 - For State Registrar	State of	Marylan		artment rtificate			and M		giene Reg. No.	)5	41500
	Physici	an	Decedent's Name (First, Middle								2. Date of De	Day	Year	3. Time of Death
-	/Media		Giuliana Denn		1 = 1						Decen	15 who	,2005	0730 M
1	Examir	er	4a. Facility Name (If not institution, Chapel Hill Nur						Location o	of Death		1	ty of Death	
			5. Social Security Number		7. Age (In yrs. I	last hirthday)	If Under		town	24 Hrs.	9 Date of Bin	Balti		place (State or Foreign
	Funeral Director		143-28-5612	1 □ M 2 💢 F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug 14	y, Year) 1925	Ital	ntry)
	ס		Usual Residence of Decedent								nag 1-		1.001	: <u>J</u>
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Importent: if Item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow importent: if Item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow injury or other traumatic event, the Medical Evantian must be retified at ance.	ctor	Md Balti	more		y, Town or Lo ndalls								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	<b>Funeral Director</b>	10e. Street and Number 3813 Cassandra	Road			10f. Zip	Code 133				10g. Citizen o	f What Cou	ntry?
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21215-0036	uraf',	d by	3 Widowed 4 Divorced	Year or Da	ites:			75					whi	
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b	Hyg other ent,	Be C	17. Father's Name (First, Middle, I	Last)					18. Mothe	r's Name	(First, Middle,	Maiden Suma	ame)	
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н		J.	Sequentially list conditions	b. Due to to	or as a consequ	lence of):								
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Вох	leath certifica attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnai		Ectopic pre	agnancy				I.	ate of delive	
-	the att	Physician/Medical	in the past 12 months? 1 □ Yes = 2 ☎No 9 □ Unknown		ant at time of de		Other (spe					N	lonth	Day Year
P.0	res that the de signed by the be detached	/ Ph	Part II. Other significant conditio	ns contributing to de	ath but not resu	alting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco use co	ntribute to t	ne cause of death?
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O a 2 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Injury 28c. Injury at Work?											8d. Describe h	now injury occu	rred	
Sio	Attending r death. ector: After by the fune	catl	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot he			M		es 2 🗆 N	-				
Division	or All after of Direction by	Certification:	4 ☐ Homicide determi	ned 286. Place	of Injury - At hor g, etc. (Specify	me, farm, str	eet, factory,	office		2	City or Tow	otreet and Num vn, State)	ber or Rura	l Route Number,
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	Vithii To the	Σ	29b. Signature and title of certifier				29c.	License				29d. Date sign		
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